REVIEW OF THE MANITOBA CONTINUING CARE PROGRAM

VOLUME I

EXECUTIVE SUMMARY

REVIEW OF THE MANITOBA CONTINUING CARE PROGRAM

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REVIEW OF THE MANITOBA
CONTINUING CARE PROGRAM

EXECUTIVE SUMMARY

This report, which is comprised of three volumes, presents the findings of a broadly based review of the Manitoba Continuing Care Program which was conducted by Price Waterhouse during October 1987 to January 1988. The review examined and made recommendations on various aspects of the Program, including its operations, management, organization and policy base.

The Manitoba Continuing Care Program is a province-wide program that provides in-home professional health services as well as various support services. Most of the services that clients receive under the Program are delivered by independent direct service workers paid on a unit of service basis. Some services also are delivered by contracted agencies such as the Victorian Order of Nurses (VON). In addition to providing home care services, the Program also is responsible for the long-term care assessment and placement function.

The review employed a number of data collection methodologies:

- interviews with government officials, service providers and consumer groups;
- surveys of clients and direct service workers;
- focus groups with direct service workers;
- visits to regional and district offices that included interviews and file reviews;
- visits to Winnipeg VON with interviews and file reviews; and,
- review of source documents.

The principal findings of the review are described in the remainder of this executive summary. They are organized under headings which correspond with the review issues that were identified at the outset of the consulting process.

Program Policies and Direction

A policy analysis of the Manitoba Program by Robert and Rosalie Kane, two prominent health care scholars, rated the Program very highly in comparison to programs in other jurisdictions. Data indicate that, in general, the Manitoba Program offers a richer mix and level of home care services than those which are found in other Canadian provinces.

The review found that the mandate of the Program has drifted as the Program is increasingly used to serve a hospital replacement function. If the Program is to adequately fulfill this additional role, it will have to place a greater emphasis on guaranteeing the availability and delivery of complex care services. This will require a policy commitment to the higher costs associated with such services. Also, the Program lacks a proper legislative base. Legislation is required in order to address a number of specific concerns with respect to the Program mandate and scope, its operations, management and policies.

Program Scope and Mandate

The review found that the Program's adult disabled clients are placing unique service demands on the Program. This raises the question of whether a unique program or service stream within Continuing Care should be established to meet their needs. The Department already has numerous recommendations on this subject from previous reports which should be acted upon.

Program Effectiveness

The review established that the stated objectives of the Program did not provide an appropriate basis for assessing effectiveness. The review identified a need to clarify objectives and to develop mechanisms for measuring program effectiveness. It also identified a need for a comprehensive quality assurance program that would gather and report information on service quality across all regions.

Client Profile

Data collection methodologies revealed that about 80% of Program clients are over 65 years of age. Almost 70% of clients are women. More than half the Program clients live alone. Of those living with others, 35% are living with people who themselves have health problems, and 30% are living with individuals who work outside the home. These findings indicate that the great majority of Program clients have limited access to support within their own households.

Clients' View of the Program

The client survey revealed a high degree of satisfaction with Program services. Eighty-seven percent of clients felt that home care services adequately met their care needs. Sixty-nine percent considered that their preferences were taken into account when the services were ordered. The survey also found that more than 40% of clients were unaware of any appeal process regarding Program services. When asked what they would have done in the absence of the Program, 48% said they would have stayed at home relying on help from families or would have used paid help. Thirty-seven percent said they would have had to move to an elderly persons housing (EPH) unit or, in some instances, to a personal care home (PCH).

Information Systems

The review identified that the Program lacks a comprehensive information system that collects and reports client, service, management and financial data on an automated basis. The review established that inadequate resources have been devoted to information systems and that there is no strategic data plan. While an enhanced payroll system is being introduced, this system will not include any client assessment data, panelling data or data on services from contracted agencies. Further, it is not clear who will be the "owner" of this new system. A short-term solution to the Program's information needs may be to obtain, at little or no cost, a system developed for and currently used in Alberta. Finally, serious concerns were identified regarding the lack of priority being given by the Health Department to addressing all long-term care health information needs.

Budgetary Control

The review identified that major administrative and workload tensions have resulted from splitting home care expenditures between two budgets: a centralized budget for purchased services; and a decentralized budget for regional staff and operating expenses. This situation has contributed to a fractured responsibility for Program spending and to a failure to manage Continuing Care as a unified program. Further, the resources to manage the Program, which are heavily constrained by the operating budget, have not kept pace with the growth in service volume caused by an open ended Home Care assistance budget. Consequently, the case coordinators and resource coordinators are experiencing high workloads.

The open ended nature of the Program raises questions as to whether there is a need for appropriate mechanisms for capping costs or services. The review examined several options in relation to the policy values that are implicit in the current Program design.

Forecasting Demand and Program Planning

The review found that the Program has lacked a practical and consistently applied method for forecasting service demands and needs. Such a method should be part of a broader program planning process. Additionally, any procedure to forecast Program demand should be linked to similar forecasting and planning processes for hospitals and personal care homes.

Management Accountability

The review revealed that the responsibility for managing the Program is too diffuse as there is minimal focus of management responsibility for the Program. It was also noted that there is an over concentration of expenditure management responsibilities in the Administrative Services Division. At the same time, regional managers lack financial management resources required to perform their management responsibilities.

Staff Training

The review identified a need for improved training in the following areas: planning and budgeting skills for Program managers; and community health care knowledge among non-baccalaureate nurse case coordinators. It also was noted that insufficient priority is attached to in-service training and continuing education.

Service Coordination

The review found that there are inadequate hospital discharge planning practices which lead to inappropriate discharges to home care, lack of proper discharge preparation and potentially unsafe client situations.

These practices could contribute to negative perceptions of the Program's home care services.

It also found gaps in services that are outside the scope of the Continuing Care Program. In some regions, the Continuing Care Program is perceived as the "deepest pocket" program and is being used to fill some of these gaps. This results in serious departures from Program guidelines, inconsistencies among regions and a sense of unfairness among staff and clients in those regions that are complying with the Program scope.

Service Delivery

Shortcomings in the regional organizational structure were identified during the review. Some Regional Continuing Care Coordinators are unable to devote all their management attention to their Program responsibilities as they also occupy other management positions, and some Program staff report to supervisors who are not part of the Program. These shortcomings undermine the overall direction and control of the Program.

The review also revealed weaknesses in the supervision of case coordinators, as some regions were functioning without supervisors. One of the regions lacking supervisors also had problems regarding case management practices. Furthermore, a quality assurance program should be developed to ensure consistent and appropriate client servicing.

Serious deficiencies in the appeal process were identified, indicating the need for a more formalized appeal process and enhanced client awareness of the process.

The review also identified the extent to which case coordinators involved in direct "hands-on" patient care, in addition to their primary role as case managers, should be clarified.

Intake, Assessment, Panelling

Significant inefficiencies were revealed during the review of the intake process. These inefficiencies stemmed from the lack of adequate screening and duplication of data collection efforts. The review also established that there was indiscriminate and inappropriate use of the joint (nurse and social worker) assessments in Winnipeg. It is estimated that between two and four staff years could be saved by terminating joint assessments in Winnipeg, in addition to savings associated with eliminating deficiencies in the screening process.

Deficiencies in the panelling process included inconsistencies in the panels' make-up, inappropriate use of panels, incomplete case preparation for panels and inadequate case presentations. In some instances, clients were being panelled simply because staff wanted to qualify them for enriched home care services and not because they were being seriously considered for institutional placement. Accordingly, these practices impact adversely on cost control objectives.

Staff Workloads

Currently, workloads for case coordinators are measured in terms of case load. For resource coordinators, workloads are measured by the number of direct service workers they supervise. The Program would benefit from a more sophisticated workload measurement approach which will provide a better basis for assigning work to staff, for staff planning and for justifying staff utilization.

The review found that workloads among case coordinators and resource coordinators were excessively high. These workloads have serious implications in terms of service delays, lack of reassessments, over servicing, greater client dependence on services and inappropriate reliance on direct service workers for case management information. Heavy workloads also resulted in direct service workers receiving inadequate supervision and resulted in inadequate contact between Program staff and clients. In summary, high workloads contribute to inappropriate servicing, unauthorized servicing, and unnecessary costs being incurred by the Program.

Direct Service Workers

Information gathered from direct service workers indicated that service workers do not identify with the Program and that they perceive a lack of organizational support. In particular, concerns were noted regarding the adequacy of training and orientation, access to supervision, and the adequacy of task instructions and scheduling.

The impending unionization of direct service workers should foster a closer relationship with the Program. This should help to address many of the concerns of the direct service workers, although it will also reduce the flexibility the Program has enjoyed in contracting them. The impending unionization of direct service workers will also have major short- and long-term cost implications for the Program.

Client Services

In the area of client services, the review identified that Program policies concerning the provision of supplies discouraged clients from assuming responsibility for their own self-care. In addition, potential over servicing (and, hence, over spending) was identified in relation to clients receiving only housekeeping services. There was also evidence of higher levels of servicing where VON was responsible for care planning and case management. The review noted that, in some regions, there was limited or no access to certain services because such services had not been developed or because of shortages of particular categories of professionals.

The review also established that when home care service costs are calculated to determine whether they are less than those of alternative forms of care, significant costs such as case management, day care, respite care, equipment and supplies are not taken into account. In many instances, home care costs actually exceed the costs of alternative forms of care. In these instances, one of the fundamental service conditions of the Program is not being followed due to the lack of consideration of all cost.

VON

There are important advantages to relying on VON to deliver nursing services in Winnipeg. However, several concerns were identified in relation to the VON's role in the Winnipeg hospitals and their role in administering the short-term program. These roles place VON in a potential conflict of interest situation where VON both order and provide services.

Additional concerns were identified regarding mechanisms to ensure VON accountability to the Program. The Department has failed to establish a service contract with VON and lacks systems to monitor VON services adequately. In fact, because such mechanisms are lacking, a situation has arisen where VON is relying on service philosophies and standards that may result in the provision of richer service levels and mixes than intended by the Program.

CONCLUSIONS

The review identified numerous strengths in the Continuing Care Program including:

- a review of the design of the Manitoba program in relation to programs in other jurisdictions by Drs. Robert and Rosalie Kane concluded that ". . . Manitoba illustrates one of the best long-term care systems in North America."
- a high level of client satisfaction with the Program;
- a committed Program staff that holds strong ideals for the role of Continuing Care services;
- a body of direct service workers who seem to derive a deep personal satisfaction from caring for Program clients;
- a Program that is strongly supported by academics, advocates of services for the elderly and the general community;
- an Office of Continuing Care that is accessible to and which maintains good communication with regional Program staff; and,
- a perception among professionals and government officials that the Program is better developed and more coherent than almost any other program in the Community Health Services portfolio.

Despite these strengths, the review has identified a number of areas where service delivery and program management could be improved. Specific recommendations are offered on how to address these shortcomings. In summary, the review points to the urgent need for the redirection of the Program in two ways:

- Focus responsibility for program management. It is not clear who is managing the Program. Key responsibilities are divided among regional managers, the Office of Continuing Care, Administrative Services and other officials. This diffusion is illustrated by the fractured budget structure for the Program. The review recommends that the regional managers be given the primary program management responsibility. They also should be given the resources and authority necessary to carry out their responsibilities (including program and financial information, regional program budgets, financial management and management staff with the requisite skills and training).

- Develop an infrastructure to ensure service integrity. The review identified a long list of problems at the operational and service levels. These problems pointed to inadequate structures and mechanisms to ensure service quality and consistency. Standards are inadequate. Supervision is often lacking. Workload management is problematic. Some clients are over serviced and others receive services that are outside program scope. Contracted agencies are not held accountable. The review recommends a comprehensive quality assurance program that would provide the structures and mechanisms to monitor program processes and outcomes. A comprehensive quality assurance program would ensure that Program services are delivered in an orderly way and that they are consistent across the province. This quality assurance program should be the responsibility of the Office of Continuing Care.

The following pages in this executive summary present ten priority recommendations that require immediate action.

1. Clarification of the Program mandate to establish the role of the Program in relation to hospital replacement services (i.e., services provided in the home to facilitate early hospital discharge, or eliminate admission to hospital).

2. Development of an automated management information system that gathers and reports client, service and financial data.

3. Formation of policies and procedures to ensure the accountability of VON for services provided under the Program, including a service contract and on-going liaison arrangements between VON and the Office of Continuing Care.

4. Introduction of a comprehensive quality assurance system to monitor and facilitate appropriate and consistent servicing across all regions. Such a system would build on existing mechanisms such as Program and caseload reviews, but would also require development work in areas such as standards, further monitoring and reporting mechanisms and procedures for evaluating actions taken.

5. Rationalization and control of Program budgets by regional management including regional budget caps.

6. Decentralization of the financial management function to regional offices.

7. Termination of dual social worker/nurse assessments in the Winnipeg Regions. One case coordinator should conduct the assessment and, where indicated, obtain a consultation from a case coordinator of the other discipline.

8. Introduction of a formalized program planning process to support budgeting and service management, which includes liaison with planning processes for hospitals and personal care homes.

9. Development of workload measurement tools to evaluate the work of coordinators and resource coordinators, and development of appropriate standards to be used in conjunction with the tool.

10. Development and enactment of specific legislation to govern the delivery of the Program.

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The following pages in this executive summary present all of the recommendations resultings from the Price Waterhouse review of the Manitoba Continuing Care Program.

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PROGRAM POLICIES AND DIRECTION - RECOMMENDATIONS

1. IN CONSULTATION WITH MHSC AND WITH INDIVIDUAL HOSPITALS, THE OFFICE OF CONTINUING CARE SHOULD REVIEW THE NEED FOR COMMUNITY-BASED HOSPITAL REPLACEMENT SERVICES (I.E., SERVICES PROVIDED ON AN IN-HOME BASIS THAT OFFER A SUBSTITUTE FOR HOSPITAL IN-PATIENT CARE) AND DETERMINE WHETHER THE CONTINUING CARE PROGRAM SHOULD ASSUME RESPONSIBILITY FOR SUCH SERVICES.

2. THE DEPARTMENT SHOULD ADOPT AN EXPANDED LONG-TERM STRATEGY TO FACILITATE THE DEVELOPMENT OF INDEPENDENT NOT-FOR-PROFIT CLEANING SERVICES IN ALL COMMUNITIES (WHERE GEOGRAPHICALLY FEASIBLE) ACROSS THE PROVINCE. THIS EFFECTIVELY SHOULD TAKE THE PROGRAM OUT OF THE BUSINESS OF PROVIDING HOUSE CLEANING SERVICES. CONSIDERATION ALSO SHOULD BE GIVEN TO INCLUDING HOUSE MAINTENANCE SERVICES ALONG WITH INDEPENDENT NOT-FOR-PROFIT CLEANING SERVICES.

3. THE GOVERNMENT SHOULD PREPARE LEGISLATION FOR THE CONTINUING CARE PROGRAM THAT DEFINES THE PURPOSE, SCOPE AND MANDATE OF THE PROGRAM.

PROGRAM SCOPE AND MANDATE - RECOMMENDATIONS

1. THE DEPARTMENT SHOULD EXAMINE THE FINDINGS AND RECOMMENDATIONS OF PREVIOUS STUDIES AND TASK FORCES ON SERVICES FOR THE ADULT DISABLED. IT SHOULD SELECT AND IMPLEMENT AN APPROPRIATE ADMINISTRATIVE STRUCTURE AND DELIVERY MODEL TO SERVE THIS POPULATION. IT IS RECOMMENDED THAT HOME CARE SERVICES FOR THE ADULT DISABLED CONTINUE TO BE ADMINISTERED THROUGH THE CONTINUING CARE PROGRAM.

2. THE OFFICE OF CONTINUING CARE SHOULD REVIEW PROGRAM OBJECTIVES WITH A VIEW TO PLACING GREATER EMPHASIS ON ACHIEVING CLIENT INDEPENDENCE. EFFORTS SHOULD BE UNDERTAKEN TO SENSITIZE CASE COORDINATORS TO THIS CONCERN.

PROGRAM EFFECTIVENESS - RECOMMENDATIONS

1. THE OFFICE OF CONTINUING CARE SHOULD RE-EXAMINE THE PROGRAM'S OBJECTIVES WITH A VIEW TO ENSURING THAT THEY FULLY REPRESENT WHAT THE PROGRAM IS INTENDED TO ACCOMPLISH. HAVING ESTABLISHED APPROPRIATE PROGRAM OBJECTIVES, THE OFFICE OF CONTINUING CARE SHOULD INTRODUCE MECHANISMS TO MONITOR THEIR ACHIEVEMENT. THE DEPARTMENT SHOULD APPROACH THE ALBERTA DEPARTMENT OF COMMUNITY HEALTH WITH A VIEW TO ADOPTING MEASURES THAT THEY HAVE RECENTLY DEVELOPED FOR THE HOME CARE OUTCOME MEASUREMENT TOOL.

2. THE OFFICE OF CONTINUING CARE SHOULD DEVELOP A COMPREHENSIVE QUALITY ASSURANCE (QA) PROGRAM. OVERALL RESPONSIBILITY FOR THE QUALITY ASSURANCE PROGRAM SHOULD BE LOCATED IN THE OFFICE OF CONTINUING CARE.

INFORMATION SYSTEMS: RECOMMENDATIONS

1. THE INFORMATION SERVICES DIVISION 1988/89 DEVELOPMENT BUDGET FOR THE HOME CARE PAYROLL SYSTEM RE-WRITE, COMMUNITY SERVICES AND CONTINUING CARE PROJECTS SHOULD BE APPROVED. NO FURTHER BUDGETARY EROSION IN THIS DIVISION SHOULD BE PERMITTED.

2. THE DEPARTMENT SHOULD GIVE PRIORITY TO THE COMPLETION OF A LONG-TERM CARE STRATEGIC DATA PLAN. THIS PLAN SHOULD BE COMPLETED AS SOON AS POSSIBLE.

3. THE INFORMATION SERVICES DIVISION SHOULD GIVE IMMEDIATE PRIORITY TO DEVELOPING A DATA STRATEGY THAT WILL ADDRESS THE INTEGRATED HOME CARE PAYROLL, CONTINUING CARE AND COMMUNITY SERVICE PROJECT.

4. THE INFORMATION SERVICE'S DIVISION SHOULD ENHANCE ITS INFORMATION CENTRE WITH A DEDICATED DATA SPECIALIST WHO WILL CONCENTRATE ON THE SHORT-TERM INFORMATION NEEDS OF CONTINUING CARE. IN THE LONGER-TERM, THE DIVISION SHOULD EXAMINE THE APPROACHES USED IN OTHER GOVERNMENT HEALTH AND HUMAN SERVICE ENVIRONMENTS FOR THE STAFFING AND OPERATION OF INFORMATION CENTRES WITH THE VIEW TO CREATING A MODEL APPROPRIATE TO MANITOBA.

5. THE ALBERTA COORDINATED HOME CARE INFORMATION SYSTEM SHOULD BE OBTAINED AS AN INTERIM SOLUTION. CLOSE COLLABORATION WITH BOTH ALBERTA AND SASKATCHEWAN IN FUTURE HOME CARE SYSTEMS DEVELOPMENT SHOULD BE PURSUED. OPPORTUNITIES FOR SHORTENED DEVELOPMENT TIMES AND REDUCED COSTS EXIST IN SUCH COLLABORATION. IT MAKES LITTLE SENSE FOR THREE WESTERN PROVINCES TO DUPLICATE EFFORTS AND COSTS IN THIS AREA WHEN THERE IS AN EXPRESSED WILLINGNESS TO SHARE AND COLLABORATE.

BUDGETARY CONTROL - RECOMMENDATIONS

1. THE DEPARTMENT SHOULD DEVELOP REGIONAL PROGRAM BUDGETS FOR REGIONAL CONTINUING CARE THAT COMPRISE OPERATING/STAFF AND HOME CARE ASSISTANCE SPENDING. THESE BUDGETS SHOULD BE MANAGED BY REGIONAL STAFF REPORTING TO THE REGIONAL DIRECTORS. THE OFFICE OF CONTINUING CARE SHOULD BE CONSULTED IN THE PREPARATION, APPROVAL AND ONGOING MANAGEMENT OF THESE BUDGETS. SUCH CONSULTATION SHOULD BE FACILITATED BY MECHANISMS TO ENSURE THE OFFICE OF CONTINUING CARE'S INFORMATION NEEDS AND CONCERNS REGARDING REGIONAL OPERATIONS ARE TAKEN INTO CONSIDERATION (E.G., EMERGING HEALTH NEEDS, CHANGES IN TECHNOLOGY AND PROVINCE WIDE POLICY INITIATIVES).

2. THE PROGRAM SHOULD REQUIRE REGIONAL PROGRAM MANAGERS TO MANAGE THEIR BUDGETS MORE ACTIVELY AND TO STAY WITHIN APPROVED LEVELS AND SHOULD GIVE PROGRAM STAFF GREATER DISCRETION OVER SERVICE LEVELS PER CLIENT (I.E., PERMITTING DILUTION OF SERVICES) IN ORDER TO ACHIEVE BUDGET TARGETS.

3. THE PROGRAM SHOULD GIVE CONSIDERATION TO INTRODUCING MEASURES THAT WOULD SERVE TO ENCOURAGE CLIENTS TO MEET THEIR NEEDS THROUGH THEIR OWN RESOURCES (E.G., USER FEES, WAITING PERIODS PRIOR TO RECEIVING NON-PROFESSIONAL SERVICES, USER FEES DURING THE INITIAL PERIOD OF SERVICE AND LIMITING HOURS IN WHICH SERVICES ARE PROVIDED).

FORECASTING DEMAND AND PROGRAM PLANNING - RECOMMENDATIONS

1. THE OFFICE OF CONTINUING CARE SHOULD DEVELOP A PRACTICAL, ROBUST METHOD FOR FORECASTING SERVICE GROWTH AND TAKING ACCOUNT OF EMERGING SERVICE TRENDS. THIS METHOD SHOULD BE USED CONSISTENTLY ACROSS ALL REGIONS.

2. A FORMAL PLANNING FUNCTION SHOULD BE ESTABLISHED IN THE OFFICE OF CONTINUING CARE. IT SHOULD ENTAIL THE APPOINTMENT OF A PROGRAM PLANNING OFFICER. SPECIFIC RESPONSIBILITIES WILL INCLUDE ORGANIZING PLANNING SESSIONS WITH REGIONAL CONTINUING CARE COORDINATORS, LIAISON WITH MHSC, DEVELOPMENT AND ANALYSIS OF PLANNING DATA BASES.

MANAGEMENT ACCOUNTABILITY - RECOMMENDATIONS

1. THE DEPARTMENT SHOULD ESTABLISH A FINANCIAL FUNCTION FOR EACH REGION. IT SHOULD ASSUME RESPONSIBILITY FOR FINANCIAL PLANNING AND REPORTING, MANAGEMENT OF FINANCIAL REPORTING SYSTEMS, CONTRACT ADMINISTRATION AND FINANCIAL CONTROLS.

2. THE DEPARTMENT SHOULD UNDERTAKE TO TRAIN EXISTING REGIONAL MANAGERS IN FINANCIAL ADMINISTRATION. COMPETENCE IN FINANCIAL ADMINISTRATION SHOULD BE MADE A REQUIREMENT FOR NEW APPOINTMENTS TO REGIONAL FINANCIAL POSITIONS.

STAFF TRAINING - RECOMMENDATIONS

1. THE PROGRAM SHOULD DEVELOP AND UNDERTAKE TRAINING PROGRAMS TO ENHANCE THE FOLLOWING AREAS:

   - PROGRAM PLANNING AND EVALUATION SKILLS AMONG OFFICE OF CONTINUING CARE, AND REGIONAL PROGRAM STAFF

   - ASSESSMENT SKILLS AMONG NON-BACCALAUREATE CASE COORDINATORS.

2. MEASURES SHOULD BE TAKEN TO ENSURE THAT RESOURCES ALLOCATED FOR IN-SERVICE TRAINING ARE NOT SACRIFICED AS A RESULT OF BUDGET PRESSURES.

SERVICE COORDINATION: RECOMMENDATIONS

1. REGIONAL OFFICES SHOULD ASSIGN RESPONSIBILITIES TO SPECIFIC CASE COORDINATORS FOR COORDINATING DISCHARGES AT EACH HOSPITAL. HOSPITALS SHOULD EACH ASSIGN RESPONSIBILITY TO A SPECIFIC STAFF MEMBER FOR COORDINATING WITH THE CONTINUING CARE PROGRAM. IN MANY INSTANCES THIS INDIVIDUAL COULD BE THE HOSPITAL DISCHARGE PLANNER.

2. BOTH THE CONTINUING CARE PROGRAM AND HOSPITAL INDIVIDUALS INVOLVED IN COORDINATION SHOULD PROVIDE ORIENTATION AND ONGOING INFORMATION SESSIONS TO HOSPITAL STAFF.

3. THE OFFICE OF CONTINUING CARE SHOULD CONTINUE TO UNDERTAKE PROGRAM AND CASELOAD REVIEWS AND SHOULD PLACE SPECIAL EMPHASIS ON ENSURING THAT ELIGIBILITY CRITERIA AND SERVICE DEFINITIONS ARE CONSISTENT WITH PROGRAM POLICIES ACROSS ALL REGIONS. IN ADDITION, THE PROGRAM SHOULD REINSTATE THE ANNUAL PROGRAM REVIEW PROCESS IN EACH REGION.

4. THE OFFICE OF CONTINUING CARE AND REGIONAL CONTINUING CARE COORDINATORS SHOULD BE RESPONSIBLE FOR IDENTIFYING EMERGING SERVICE ISSUES AND ENSURING SWIFT PROGRAM POLICY DECISIONS IN RESPONSE.

SERVICE DELIVERY: RECOMMENDATIONS

1. THE PROGRAM SHOULD ESTABLISH MINIMAL ORGANIZATIONAL REQUIREMENTS:

   - THE REGIONAL CONTINUING CARE COORDINATOR POSITIONS SHOULD BE FULL-TIME AND INDIVIDUALS HOLDING THESE POSITIONS SHOULD NOT BE GIVEN OTHER SIGNIFICANT RESPONSIBILITIES SUCH AS AREA MANAGEMENT ROLES;

   - IN REGIONAL ORGANIZATIONAL STRUCTURES, CONTINUING CARE PROGRAM STAFF SHOULD REPORT TO SUPERVISORS IN THE CONTINUING CARE PROGRAM;

   - EACH REGION SHOULD BE RESPONSIBLE FOR ASSIGNING RESOURCE DEVELOPMENT RESPONSIBILITIES TO APPROPRIATE PROGRAM STAFF.

   COMPLIANCE WITH THESE ORGANIZATIONAL REQUIREMENTS SHOULD BE MONITORED THROUGH THE PROGRAM REVIEW PROCESS.

2. STAFF SHOULD BE APPOINTED IN EACH REGION TO SUPERVISE CASE COORDINATORS. THESE RESPONSIBILITIES SHOULD NOT BE GIVEN TO THE REGIONAL CONTINUING CARE COORDINATOR. THERE SHOULD BE AT LEAST ONE SUPERVISOR FOR EVERY EIGHT CASE COORDINATORS. IN SOME REGIONS, THIS WILL REQUIRE ADDITIONAL STAFFING RESOURCES.

3. CASELOAD REVIEW SHOULD BE USED TO MONITOR CASE COORDINATOR SERVICE DELIVERY DECISIONS AND ANY SHORTCOMINGS IN SUPERVISION. FURTHER, ASSESSMENT CHARTING STANDARDS SHOULD BE DEVELOPED AND ASSESSMENT CHART AUDITS REGULARLY INCORPORATED IN THE CASELOAD REVIEW PROCESS.

4. A WRITTEN PAMPHLET OUTLINING THE CLIENT APPEAL PROCESS SHOULD BE PREPARED. IT SHOULD BE MADE AVAILABLE TO PROGRAM STAFF AND DISTRIBUTED TO ALL CLIENTS ON ADMISSION. CLIENTS SHOULD SIGN A FORM INDICATING AWARENESS OF THE PROCESS. AT THE TIME OF REASSESSMENT OR AT SERVICE CHANGE, CLIENTS SHOULD BE ADVISED AGAIN OF THE APPEAL PROCESS. THE OFFICE OF CONTINUING CARE SHOULD ESTABLISH A MECHANISM TO MONITOR CLIENT AWARENESS OF APPEAL PROCEDURES. THIS COULD ENTAIL AN ANNUAL AUDIT INVOLVING TELEPHONE INTERVIEWS WITH A SMALL SAMPLE OF CLIENTS.

5. THE OFFICE OF CONTINUING CARE SHOULD ELIMINATE THE RESPONSIBILITIES FOR CASE COORDINATORS REGARDING PROVISION OF DIRECT SERVICE (E.G., COUNSELLING/TEACHING). THE RESULTS OF THIS CHANGE SHOULD BE TAKEN INTO ACCOUNT IN IDENTIFYING STAFF YEAR REQUIREMENTS.

INTAKE/ASSESSMENT/PANELLING: RECOMMENDATIONS

1. PRE-ASSESSMENT SCREENING SHOULD BE INTRODUCED IN ALL REGIONS. THIS SCREENING SHOULD BE PERFORMED BY PROFESSIONAL STAFF. THE PROGRAM SHOULD ALSO DEVELOP A MECHANISM TO FLAG SELECTED CASES WHO ARE SCREENED OUT FROM ASSESSMENT. THESE CASES SHOULD BE FOLLOWED UP TO ENSURE THEIR NEEDS HAVE BEEN MET.

2. THE OFFICE OF CONTINUING CARE SHOULD TERMINATE THE JOINT (SOCIAL WORKER AND NURSE) ASSESSMENT PROCESS AND SHOULD DEVELOP CRITERIA TO IDENTIFY INSTANCES WHERE A CONSULTATION FROM A CASE COORDINATOR OF ANOTHER DISCIPLINE IS INDICATED.

3. THE PROGRAM SHOULD IDENTIFY PANEL MEMBERSHIP REQUIREMENTS. THESE SHOULD BE APPLIED CONSISTENTLY ACROSS ALL REGIONS.

4. FURTHER GUIDELINES SHOULD BE DEVELOPED REGARDING REQUIRED FORMATS FOR CASE PREPARATION AND PANEL PRESENTATIONS. SUCH GUIDELINES WOULD SPECIFY REQUIRED CONTENT IN PREPARED CASE MATERIAL AND AREAS TO BE COVERED IN PANEL PRESENTATIONS.

5. THE OFFICE OF CONTINUING CARE SHOULD DEVELOP MECHANISMS TO MONITOR THE APPROPRIATE USE OF THE PANEL PROCESS INCLUDING A DOCUMENTATION AUDIT OF PREPARED CASE MATERIAL AND PANEL DECISIONS AND AN ON-SITE PANEL REVIEW PROCESS BY OFFICE OF CONTINUING CARE STAFF. (THIS PROCESS WOULD PARALLEL THE CASELOAD REVIEW PROCESS.)

STAFF WORKLOADS: RECOMMENDATIONS

1. THE OFFICE OF CONTINUING CARE SHOULD COMMISSION A PROJECT TO: A) IDENTIFY AND REVIEW EXISTING TOOLS FOR USE IN MANAGING CASE COORDINATOR AND RESOURCE COORDINATOR WORKLOADS AND B) DEVELOP, TEST AND COMPARE PROVINCE-WIDE WORKLOAD MEASUREMENT TOOLS FOR CASE COORDINATORS AND RESOURCE COORDINATORS RESPECTIVELY.

2. UNTIL NEW WORKLOAD MEASUREMENT METHODS ARE DEVELOPED AND APPLIED, THE DEPARTMENT SHOULD ADOPT INTERIM MEASURES TO STAFF TO THE CURRENT WORKLOAD STANDARDS. TO AVOID ANY COMMITMENTS THAT WILL NOT BE SUPPORTED BY FUTURE STANDARDS, ADDITIONAL STAFF SHOULD BE HIRED ON A TERM BASIS.

DIRECT SERVICE WORKERS: RECOMMENDATIONS

1. THE DEPARTMENT SHOULD CONTINUE TO PROVIDE THE HOME CARE ATTENDANT/HOME SUPPORT WORKER COURSE THROUGH RED RIVER COLLEGE. THIS COURSE SHOULD BE EXPANDED TO INCLUDE EMERGENCY TRAINING (E.G., CARDIO PULMONARY RESUSCITATION AND EMERGENCY FIRST AID) AND BE AVAILABLE TO ALL WORKERS IN THE PROGRAM.

2. REGIONAL OFFICES SHOULD DEVELOP AND MAKE ACCESSIBLE TO DIRECT SERVICE WORKERS A LOCAL POLICY AND PROCEDURE MANUAL ADDRESSING CLIENT CARE PRACTICES. THIS MANUAL SHOULD BE UPDATED REGULARLY.

3. EACH REGIONAL OFFICE SHOULD DEVELOP AND IMPLEMENT A FORMAL ORIENTATION PROGRAM FOR ALL DIRECT SERVICE WORKERS. THIS PROGRAM SHOULD INCLUDE, AS A MINIMUM, AN OVERVIEW OF THE CONTINUING CARE PROGRAM'S GOAL AND OBJECTIVES, LOCAL POLICY AND PROCEDURE INFORMATION, EMERGENCY PROTOCOLS, AS WELL AS AN INTRODUCTION TO OFFICE AND PROGRAM STAFF. THIS RESPONSIBILITY SHOULD BE DELEGATED TO THE RESOURCE DEVELOPER. DIRECT SERVICE WORKERS SHOULD NOT RECEIVE CLIENT ASSIGNMENTS UNTIL THEY HAVE COMPLETED THE ORIENTATION PROCESS.

4. REGIONAL OFFICES, IN CONSULTATION WITH THE OFFICE OF CONTINUING CARE, SHOULD PLAN AND IMPLEMENT A CONTINUING EDUCATION PROGRAM FOR ALL DIRECT SERVICE WORKERS ENSURING THAT KNOWLEDGE AND SKILLS ARE MAINTAINED AND UPDATED (INCLUDING REGULAR CARDIO PULMONARY RESUSCITATION CERTIFICATION AND EMERGENCY FIRST AID UPDATES). THE OFFICE OF CONTINUING CARE SHOULD ENSURE THE PROGRAM RESOURCE SPECIALIST OVERSEES THIS PROCESS.

5. ALL WORK INSTRUCTIONS TO DIRECT SERVICE WORKERS MUST BE IN WRITING, PROVIDING SUFFICIENT CLIENT INFORMATION TO ENSURE SAFE, APPROPRIATE CARE. WORK CLARIFICATION QUESTIONS SHOULD BE DIRECTED TO THE

RESOURCE COORDINATOR WHO, IN TURN, SHOULD CONTACT THE CASE COORDINATOR FOR FURTHER CLARIFICATION IF NEEDED.

6. DIRECT SERVICE WORKERS, WHEN APPROPRIATE, SHOULD BE INVOLVED IN CLIENT CASE CONFERENCES.

7. REGIONAL OFFICES SHOULD ENSURE THAT ALL DIRECT SERVICE WORKERS RECEIVE REGULAR IN-PERSON FEEDBACK ON THEIR PERFORMANCE. A FORMAL PERFORMANCE APPRAISAL SHOULD BE CONDUCTED ON AN ANNUAL BASIS.

8. REGIONAL OFFICES SHOULD ASSIGN PROGRAM STAFF TO DEAL WITH DIRECT SERVICE WORKERS' QUESTIONS/DILEMMAS AFTER WORKING HOURS AND ON THE WEEKENDS. THE DIRECT SERVICE WORKERS SHOULD BE INFORMED, IN ADVANCE, OF WHOM TO CONTACT AFTER HOURS.

CLIENT SERVICES - RECOMMENDATIONS

1. THE OFFICE OF CONTINUING CARE SHOULD REVIEW THE POLICY REGARDING SELF-CARE PATIENTS IN RELATION TO THE PROVISION OF SUPPLIES. A SOLUTION SHOULD BE SOUGHT WHICH MOTIVATES CLIENTS TO ASSUME SELF CARE.

2. THE OFFICE OF CONTINUING CARE SHOULD USE CASELOAD REVIEW DATA TO IDENTIFY GAPS IN COMMUNITY RESOURCES ACROSS THE PROVINCE AND SUBSEQUENTLY SHOULD ASSESS THE RELATIVE COST EFFECTIVENESS OF TWO ALTERNATIVE STRATEGIES:

   - CONTINUE TO HAVE THE OFFICE OF CONTINUING CARE PURCHASE SERVICES IN SPECIFIC COMMUNITIES; AND

   - CONCENTRATE EFFORTS ON DEVELOPING INDEPENDENT SERVICE RESOURCES (E.G., MEALS ON WHEELS)

3. THE DEPARTMENT SHOULD EXPLORE PROVIDING ADDITIONAL INCENTIVES TO RECRUIT PROFESSIONALS TO THE NORTHERN AND REMOTE AREAS OF THE PROVINCE.

4. THE OFFICE OF CONTINUING CARE SHOULD CLARIFY THAT THE SERVICE LEVEL LIMITS DO NOT TAKE INTO ACCOUNT THE COSTS OF THE FULL RANGE OF COMMUNITY SERVICES. (SPECIFICALLY, THEY DO NOT INCLUDE CASE MANAGEMENT, DAY CARE, RESPITE CARE, COMMUNITY THERAPY SERVICES, SUPPLIES AND EQUIPMENT.)

VICTORIAN ORDER OF NURSES - RECOMMENDATIONS

1. THE OFFICE OF CONTINUING CARE SHOULD, IN CONSULTATION WITH THE VON, PLAN FOR THE CONTINUING CARE PROGRAM REGIONAL OFFICES TO ASSUME RESPONSIBILITY FOR CASE MANAGEMENT OF SHORT-TERM CASES IN WINNIPEG. IMPLEMENTATION OF THIS MEASURE SHOULD TAKE PLACE WITHIN 18 MONTHS OF INITIATION OF THE PROCESS. THE PROGRAM WILL HAVE TO HIRE AT LEAST 27 ADDITIONAL STAFF TO CARRY OUT THESE RESPONSIBILITIES, ASSUMING CURRENT SHORT-TERM CASELOADS AND EXISTING CASELOAD STANDARDS.

2. THE VICTORIAN ORDER OF NURSES' STAFF IN WINNIPEG HOSPITALS (REFERRAL NURSES AND CASE COORDINATORS) SHOULD BE REPLACED PROGRESSIVELY BY NURSES REPORTING TO THE CONTINUING CARE PROGRAM. WHERE NUMBERS WARRANT, CONTINUING CARE ALSO SHOULD LOCATE NURSING SUPERVISORS IN THE HOSPITALS. MANAGEMENT RESPONSIBILITY FOR THESE NEW CONTINUING CARE PROGRAM STAFF SHOULD BE GIVEN TO ONE OF THE WINNIPEG REGIONAL OFFICES. THE PROGRAM WILL HAVE TO HIRE AT LEAST 23 ADDITIONAL STAFF TO CARRY OUT THESE RESPONSIBILITIES IN ORDER TO MAINTAIN CURRENT STAFFING LEVELS FOR THESE FUNCTIONS.

3. THE OFFICE OF CONTINUING CARE, IN CONSULTATION WITH VON, SHOULD DEVELOP A CONTRACT TO COVER SERVICES PURCHASED FROM VON UNDER THE PROGRAM AND AN UNDERSTANDING THAT VICTORIAN ORDER OF NURSES WILL DELIVER SERVICES IN A MANNER CONSISTENT WITH PROGRAM POLICIES. IT SHOULD INCLUDE AN AGREED UPON COST PER VISIT. THIS CONTRACT SHOULD BE RENEWED ANNUALLY.

4. THE OFFICE OF CONTINUING CARE AND VON SHOULD EACH ASSIGN RESPONSIBILITY TO INDIVIDUAL STAFF MEMBERS FOR ONGOING LIAISON BETWEEN THE TWO ORGANIZATIONS. THESE INDIVIDUALS SHOULD MEET ON AT LEAST A QUARTERLY BASIS TO DISCUSS MUTUAL CONCERNS.

Volume

2

Price Waterhouse

REVIEW OF THE MANITOBA CONTINUING CARE PROGRAM

VOLUME II

REPORT

REVIEW OF THE MANITOBA CONTINUING CARE PROGRAM

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PART I: OVERVIEW OF REVIEW

1. THE MANITOBA CONTINUING CARE PROGRAM - INTRODUCTION

Since its inception in 1973/74, the Manitoba Continuing Care Program has grown dramatically. In 1975/76, the Program was spending $4.7 million on services. By 1986/87, this figure was $36.8 million. Due to these increasing Program expenditures, the Manitoba Government has authorized Price Waterhouse to review the Program, assess its performance, take stock of its current operations and management structure and make recommendations for its future.

The Continuing Care Program is recognized widely by professionals and planners in other jurisdictions as a model program. This recognition stems, in part, from the fact that the Program has several key features that have been of interest to advocates of home care. They include:

- universality, with services being provided to all clients in need at no charge;
- emphasis on the social component, particularly in its client assessment process; and,
- linkage of institutional placement with home care through inclusion of a placement panelling process in the program functions.

The Program has seven stated objectives (Continuing Care Policy Guidelines and Program Manual, p. 3):

- to provide an assessment for care which determines whether a person's care needs can be met appropriately at home or whether the person requires an institutional setting to meet care needs;
- to develop and provide services in the home setting as a viable form of care;

- to provide services at home as an alternative to institutional care for those for whom care at home is most appropriate;

- to facilitate placement into care facilities for those for whom care at home is not appropriate;

- to relieve excess stress on family members and, in so doing, prevent the breakdown of a desirable living arrangement and/or the health of the person/persons providing care;

- to prevent the premature, expensive or unnecessary placement of persons in care facilities (including hospitals) and thus prevent the unnecessary building and utilization of institutional facilities; and,

- to continuously evaluate the impact of the Continuing Care Program on the target population and other Health Care delivery systems.

The Program is administered at several levels and locations. It is administered centrally by the Office of Continuing Care, which is part of the Community Health Services Division of the Department of Health. Regionally, the Program is administered by regional offices, designated District Health Centres and designated hospitals/agencies.

The Continuing Care Program provides two major functions: home care services including adult day care and respite care; and, assessment for care facility placement.

The Program was introduced at the same time that the Province was making nursing home care an insured benefit. It was intended that home care services provided under the Program would alleviate some of the need for more expensive institutional forms of care. Home care services provided under the Program include the following:

- visiting nursing services;
- occupational therapy services;
- physiotherapy services;
- homemaker services; and,
- personal care services.

These services generally are purchased from direct service workers or contracted agencies. The direct service workers are not government employees. Rather, they are freelance workers paid on the basis of units of service provided. The contracted agencies are agencies such as the Victorian Order of Nurses (VON) and Community Therapy Services (CTS) from which services are purchased. In the 1986/87 fiscal year, 79% of the budget for purchased services (the Home Care Assistance Budget) was spent on direct service workers compared to 24% for contracted agencies (21% to VON and 3% to other agencies).

While actual Home Care services are generally provided by independent providers, responsibility for assessing client need and coordinating client services, in most instances, lies with staff in the Department of Health. The main exception to this arises with short-term cases (i.e., those expected to receive services for less than 60 days) in Winnipeg where the VON assumes the case coordination role.

In addition to delivering Home Care services, the Program is also responsible for the institutional placement function. This involves the evaluation of clients, decision making on whether placement is required and the coordination of admissions to institutional long-term care facilities such as personal care homes. Originally, this function was included in the Program because it was considered that one central organization responsible for both Home Care and institutional placement could prevent the institutionalization of clients who could have been maintained in the community with the support of Home Care services.

REPORT FORMAT

This report presents the findings of a broadly based review of the Continuing Care Program. The report is organized into six parts. Part I presents the review issues and the methodology. Part II examines program policy, scope and mandate, and program effectiveness. Part III presents a description of the program clients and findings on clients' perceptions of the Program. Most of the findings in this section are derived from a survey of program clients. Part IV reviews program management and focuses on information systems, budgeting, forecasting demand, management accountability, program mandate and program effectiveness. Part V reviews key operational aspects of the Program, including service co-ordination, service delivery, program processes, service workload levels and the program service providers. Finally, Part VI of the report presents implementation options for the review recommendations, which are contained in each section of the report.

2. REVIEW ISSUES

The Terms of Reference for this study (Appendix A) contained a series of questions to be addressed by the Review. In the initial stages of the study, the review questions were grouped under 15 issues. The issues served to focus the methodology and to facilitate the data collection process. The 15 issues are presented below.

1) Program scope and mandate. Several questions were raised in the Terms of Reference concerning the objectives and the scope of the Program in relation to such services as day care and respite care. These questions focused on the definition and appropriateness of the program's mandate and scope.

2) Achievement of program objectives. The Terms of Reference also raised questions concerning the effectiveness of the Program in relieving pressure on families, facilitating de-institutionalization and in improving clients' health outcomes. While it was recognized that to address these questions fully would require an elaborate evaluation research undertaking, this review was expected to identify and synthesize information that would permit some tentative conclusions in relation to these issues.

3) Forecasting demand and utilization. For seven of the last nine years, the actual amount spent on Home Care services has exceeded that requested in the budget preparation process. As a result, the review was to address concerns raised about the adequacy of forecasting mechanisms and program planning.

4) Budget control. Given the rapid growth of the Program in recent years, questions have been raised about the appropriateness of the current financial and budget structure. This represents one of the most important issues underlying this review.

5) Information systems. The Program has no central automated information system that could produce reports on client, service and financial information. The review was expected to address this issue and assess options for establishing information systems for the Program.

6) Management accountability and control. Several questions were identified for the review relating to the organization and management accountability for the Program.

7) Role and accountability of VON. This issue concerns the appropriate role for VON in the Program, and how VON could be held accountable to the Program for the Home Care services it provides.

8) Service coordination. The review was also directed to examine the interface of the Program with other health services, in particular hospital and personal home care services.

9) Mix and deployment of field staff. The Terms of Reference also required the review to assess the appropriateness and mix of staff used to deliver program services.

10) Appropriateness of intake/assessment/panelling procedures. The review was also required to look at the various assessment and case management practices followed with a view to assessing their effectiveness and uniformity. Regional variations were examined.

11) Staff workloads. Staffing levels in the Program have not kept up with increases in service volume. The review was to examine factors contributing to this situation, assess implications and offer conclusions regarding workload standards.

12) Level of client servicing. Given the growth in service volume under the program and current fiscal constraints in government, the review was directed to address the appropriateness of current levels of client servicing and, in particular, to identify any areas of over-servicing.

13) Relationship of the Program with special needs populations. The Continuing Care Program was originally intended to primarily meet the needs of the elderly. Questions have been raised about the appropriate role of the Program in relation to other special needs populations such as the adult disabled, the chronic psychiatric, the developmentally handicapped and children with high medical risks.

14) Service provider input. The review was also directed to gather the views of direct home care service workers on the Program and on their general work morale.

15) Adequacy of staff training/skills. The review also addressed questions related to the adequacy of staff skills and training to perform their responsibilities under the Program.

These 15 issues are addressed in the findings sections in Parts II through V of this report.

3. REVIEW METHODOLOGY

This chapter presents the methodology utilized in conducting the Review of the Manitoba Continuing Care Program.

Review data were obtained through several methods:

- interviews;
- surveys;
- focus groups;
- regional/short term care agency visits; and,
- review of source documents.

Each of the five major data collection methods will be outlined and described briefly in the following sections. Exhibit 1, following, depicts the data collection source/method for each of the fifteen review issues.

INTERVIEWS

During the course of the review, meetings with groups of individuals and/or individual interviews were conducted with persons affiliated with each of the following seven groupings:

- Office of Continuing Care;
- Manitoba Health Services Commission;
- Provincial Department of Health;
- Treasury Board;
- Community Therapy Services;
- Consumer Advocacy Groups; and,
- Urban Hospitals.

A complete list of those with whom meetings and/or interviews were held is contained in Appendix B.

Exhibit 1

DATA COLLECTION SOURCE/METHODOLOGY

Issue/Date Source	Kane/Kane Report	Central /Agency Interviews	Client Survey	Service Worker Question-naire	Prof.Assoc. Letter	Focus Groups	Regional /V.O.N. visit	Review of Source Documents
1. Program Scope and Mandate	*	*	*		*		*	*
2. Achievement of Program objectives	*	*	*		*		*	*
3. Forecasting Demand and Utilization	*	*					*	*
4. Budget Control		*					*	*
5. Information Systems	*	*					*	*
6. Management Accountability & Control		*					*	*
7. Role & Accountability of V.O.N.		*	*		*		*	*
8. Service Coordination		*		*			*	*
9. Service Delivery		*	*	*		*	*	*
10. Appropriateness of Intake/Assessment /Panelling Procedures	*	*					*	*
11. Staff Workloads		*		*		*	*	*
12. Level of Client Servicing		*	*	*		*	*	*
13. Relationship of Program with special needs population	*	*			*		*	*
14. Service Provider Inputs				*		*	*	
15. Adequacy of Staff Training /Skills		*		*		*	*	*

* data source used relative to issue presented

Discussions with each of the groups varied slightly in terms of content depending on the interviewee's position and/or grouping. All questions asked, however, were designed to capture information relative to the fifteen review issues discussed in the previous chapter. To facilitate consistent data collection, interview guides listing the questions to be explored during the meeting were utilized. In addition, whenever possible the questions were circulated in advance.

SURVEYS

The review contained three surveys involving:

- clients;
- direct service workers; and,
- professional associations.

Each survey is outlined briefly below.

Client Survey

One thousand clients deemed eligible for the survey participated in a 15 minute telephone interview. Eligible clients consisted of non-hospitalized individuals who were either: currently receiving home care services; or, who had received home care services within the three months preceding the survey.

The central registry, housed at the Office of Continuing Care, served as the sampling frame. Using a random start and systematic selection process, approximately 3200 client cards were drawn from the rotary wheels. The client cards were stratified by client location and age, photocopied, and mailed to the respective region for verification. In addition to verifying client registry information, regional continuing care representatives:

- advised client/family of the survey using a briefing letter submitted for distribution;

- listed the home care services currently received by each client; and,

- identified any barriers to survey participation such as sensory motor impairments, language difficulties and so on.

The survey questionnaire itself (Appendix C) contained mainly closed ended questions dealing with the following client information:

- demographic;
- housing;
- family support;
- service satisfaction; and,
- awareness of the appeal process.

Prior to the start of the survey, the questionnaire was pretested on 15 individuals and modified accordingly. During the survey, trained interviewers obtained client consent at the outset of the interview. In addition, regional quotas were established and followed to ensure proportionate client representation from the 10 provincial regions, the short term care agency (VON) and urban hospitals. Upon survey completion the data results were coded, entered into the computer, verified and analyzed.

Direct Service Workers

Approximately 3600 direct service workers whose names appeared on the Home Care Payroll List received a three part package with one of their December payrolls. This package contained an explanatory letter, a comment form questionnaire, and a postage paid return envelope.

The comment form questionnaire (Appendix D) solicited direct service worker input in the following areas:

- orientation and training;
- work instructions;
- supervision;
- client services; and,
- job satisfaction.

The initial questionnaires were analyzed and a coding scheme developed from which the remaining questionnaires were coded. Comment results were then summarized and analyzed.

Professional Associations

Twenty of Manitoba's relevant professional associations were identified and contacted for comments regarding the Continuing Care Program. A letter (Appendix E) was mailed out asking for the organization's view points relative to the Continuing Care Program:

- scope and mandate;
- organization;
- operations; and,
- effectiveness.

Upon receipt, the responses were summarized and analyzed.

FOCUS GROUPS

With direct service workers, four focus groups were also conducted in the regions of Norman, Eastman, Westman, and Winnipeg South.

The hosting Regional Continuing Care Coordinator selected 12 individuals for participation; three from each type of service provider group:

- Registered Nurses - RN
- Licensed Practical Nurses - LPN
- Home Care Attendants - HCA
- Home Support Workers - HSW

A series of structured questions covering material similar to that of the comment form questionnaire served as the basis for the two to four hour focused group discussion (Appendix F). At the conclusion of each session, the recording secretary and moderator summarized and analyzed the observations and findings.

REGIONAL/VON VISITS

All 10 provincial regions as well as the Short Term Care Agency were visited. The visits occurred in two phases, each of which is described below.

Phase One

During the first phase, three regions plus the short term care agency for Winnipeg were selected for an intensive review: Parklands, Interlake, Winnipeg North, and The Victorian Order of Nurses (VON).

The rationale for selecting the above regions was their suitability as representatives of rural, rural/urban and urban areas (respectively). VON was included in the intensive review because of its unique characteristics within the program as the administrating agency for short-term care in Winnipeg.

Between three and four consultants with extensive and varied front line community experience spent approximately three days in each location conducting the following activities:

REVIEWS OF -

- client files;
- monthly statistics; and,
- financial reports.

OBSERVATION OF -

- panelling;
- intake assessment; and,
- case and/or caseload review.

INTERVIEWS WITH -

- Regional Director/Executive Director;
- Regional Continuing Care Coordinator/STC Agency Director;
- Area Coordinator/Supervisor;
- Resource Developer;
- Resource Coordinator;
- Case Coordinator/Hospital Referral Nurse;
- Administrative Officer and/or Payroll Clerk; and,
- Direct Service Workers (RN/LPN/HCA/HSW).

To ensure consistent data collection among regions and between consultants, guides were developed and used for all activities.

The interview guide (Appendix G) focused on covering material pertaining to the fifteen review issues. The Panelling (Appendix H), Intake Assessment (Appendix I), and Case Review (Appendix J) observation guides focused on providing the observer with information necessary to fully comprehend the process observed. Similarly, the Client File Review Guide (Appendix K) enabled the consultant to obtain important insights into the case management process of the case coordinator. Approximately 10-15 client files were selected at random from each of the four areas for review.

Phase One of the regional visits ended with the consultants summarizing and analyzing their findings relative to the fifteen review issues.

Phase Two

In phase two, the regional visits involved visiting the remaining seven regions (Thompson, Norman, Eastman, Westman, Central, Winnipeg West Central and Winnipeg South). During the one day visit, interviews were held with the following individuals:

- Regional Director
- Regional Continuing Care Coordinator
- Supervisor/Team Leader
- Case Coordinator
- Resource Developer
- Resource Coordinator
- Administrative Officer

A revised version of the original interview guide (Appendix L) was used to conduct the interviews.

In addition to the interviews, approximately three client files were selected randomly and reviewed using the review guide previously described. Regional findings were summarized and analyzed according to the review issues.

REVIEW OF SOURCE DOCUMENTS

Documentation relevant to enhancing the understanding of the operational activities and organization of the Continuing Care Program was reviewed. Material was obtained from varied and numerous sources. A complete list of the sources is contained in Appendix M.

PART II : PROGRAM POLICY AND EFFECTIVENESS

In this section of the report, key areas of program design, program policies and program effectiveness are reviewed. There are three chapters which cover:

- Program Policies and Direction
- Scope and Mandate (issue #1 in Chapter 2)
- Program Effectiveness (issue #2 in Chapter 2)

4. PROGRAM POLICIES AND DIRECTION

The terms of reference (Appendix A) for this review raise some key policy questions regarding the Continuing Care Program. These include questions on program scope and mandate; the relationship of Continuing Care to other health and support services; the populations served by the Program; who should deliver services; whether there are alternatives to home care; and so on. Another important theme that runs through many of the questions in the terms of reference is the question of whether the program service levels are appropriate and whether, indeed, the program is not too rich in the sense of providing more services than are really required. The extensive fact gathering that was entailed in this review provides insights into these questions.

Given the nature of some of these questions, the Review included a broad policy assessment of the Manitoba Continuing Care Program in relation to similar programs in other jurisdictions. This assessment was conducted by two world-renowned scholars in the field of long-term care and caring for the elderly, Drs. Robert and Rosalie Kane (see Addendum). Their overall assessment of the Manitoba program was a positive one. In particular, they comment favorably on the universality (i.e., services are not limited to specific income or social groupings) of Continuing Care and other long-term care services in the province, noting that:

> "...universal long-term care benefits were not only a humane and equitable public policy (compared to the financial hardships that fall on families needing long-term care in the United States), but also that universal long-term care benefits with governments as major purchasers of service can lead to high quality care at lower total costs... we regard Manitoba's programs, including the Continuing Care Program, as positive models of long-term care. In our view, Manitoba illustrates one of the best long-term care systems in North America."

The remainder of this chapter addresses some of the most important policy issues raised in the course of the review:

- whether program service levels are too rich;
- emerging demands for home care, particularly hospital replacement services;
- the appropriateness of services being covered by the Program, in particular house cleaning and meal preparation; and,
- whether the program requires a specific legislative base.

Some of these issues recur again in later parts of this report in relation to program management and program operations.

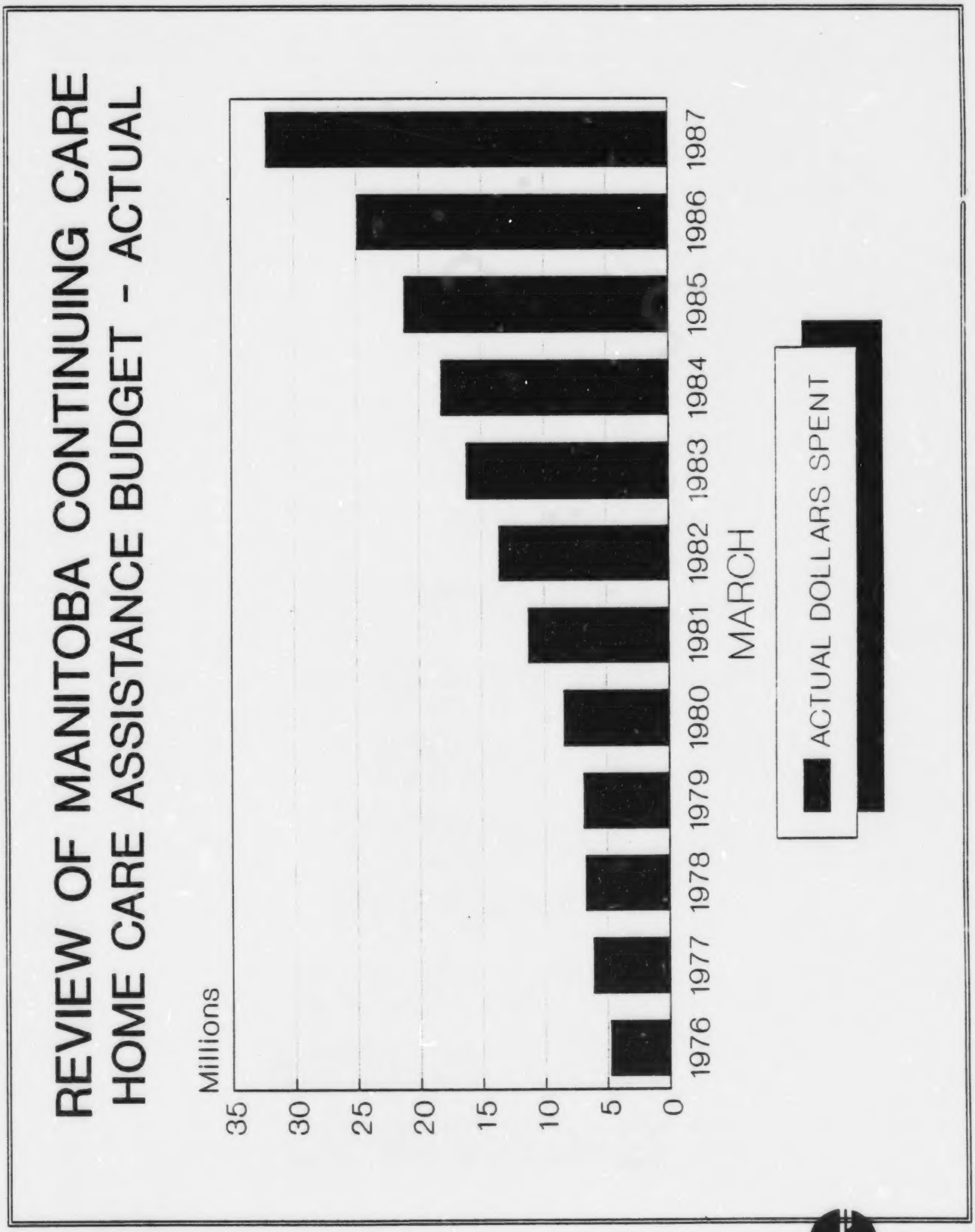
The "Richness" Issue

The annual growth in the Program's service budget has averaged 19% over the past 12 years (see Exhibit 2, following). This growth in spending is associated with a growth in the number of cases served and in the number of units of service being provided (Exhibits 3 and 4, following). In Exhibit 5, following, we examine the relationship between the growth in the program budget and that of services provided and caseload. It demonstrates quite clearly that the growth in spending is explained, in large part, by the growth in caseloads and service units. It shows also that the units of service have grown at a faster rate than caseload. Thus, it can be concluded that the number of units of service per case has increased progressively. In 1981, the average number of service units per case was 199. In 1986, the figure was 293.

Average Number of Service Units per Case, 1981-1987

Year	Average Number of Service Units
1981	199
1982	206
1983	188
1984	202
1985	211
1986	293
1987	280

Exhibit 2



REVIEW OF MANITOBA CONTINUING CARE
HOME CARE ASSISTANCE BUDGET - ACTUAL

Exhibit 3

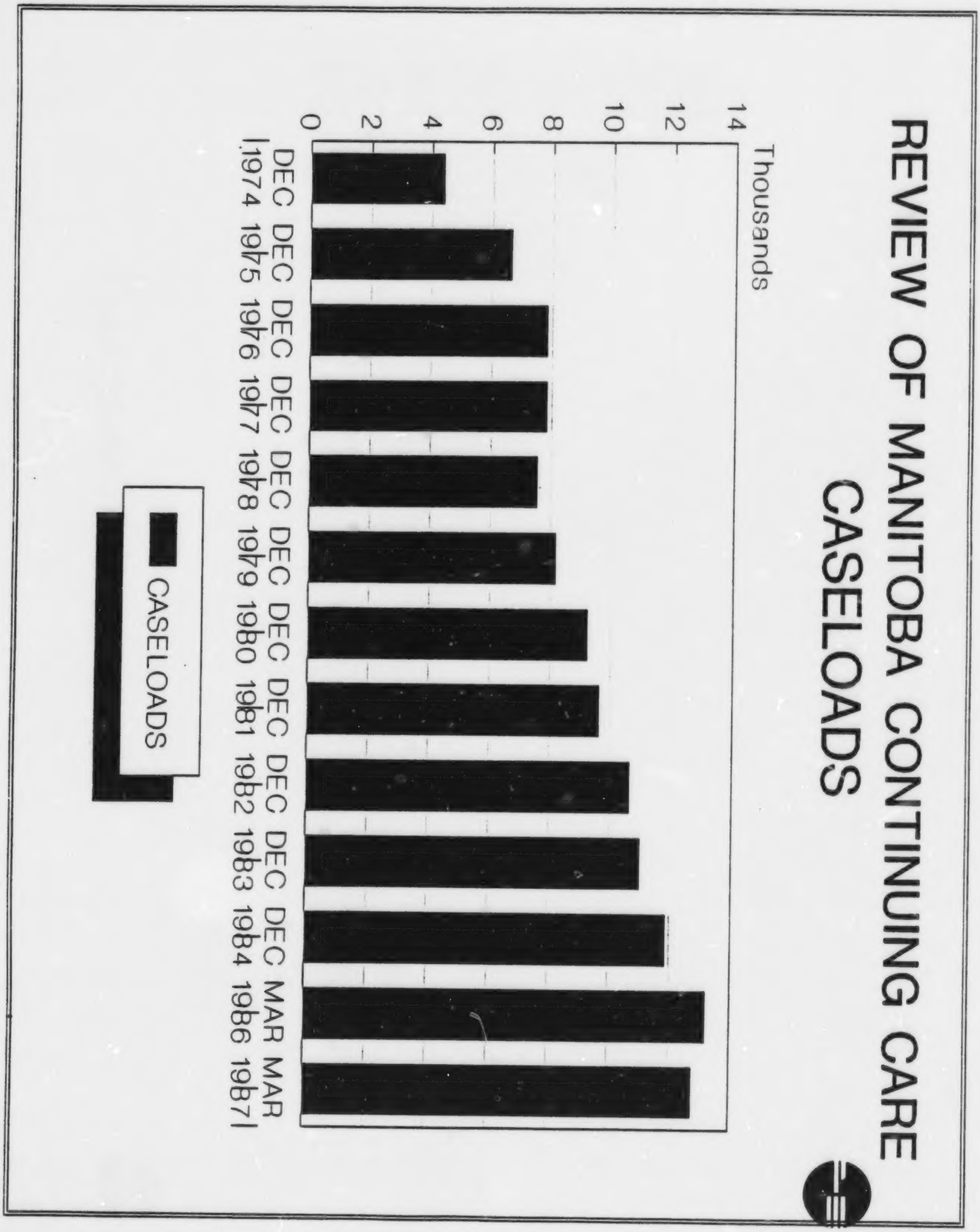
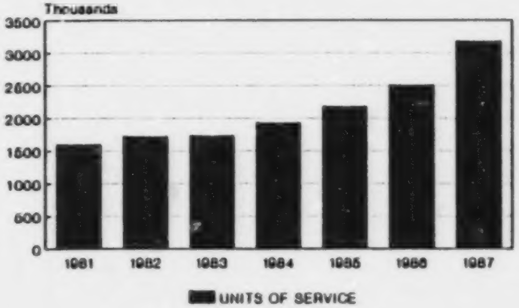

REVIEW OF MANITOBA CONTINUING CARE CASELOADS

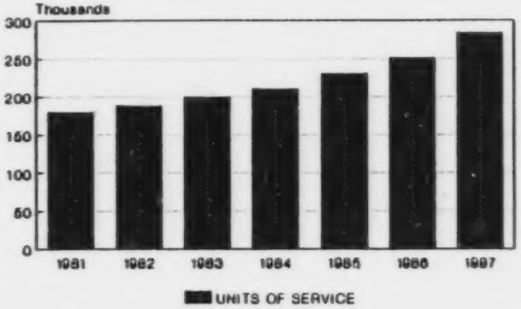
Exhibit 4

REVIEW OF MANITOBA CONTINUING CARE

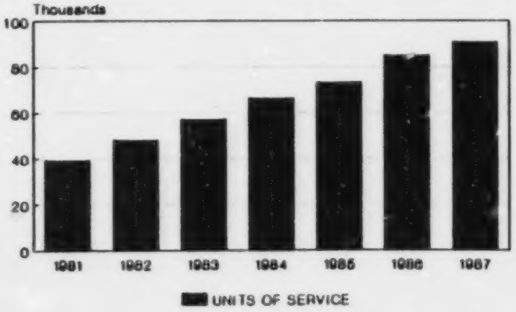
UNITS OF SERVICE



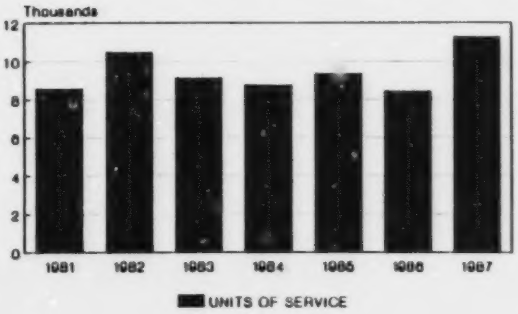
HOMEMAKERS



REGISTERED NURSES

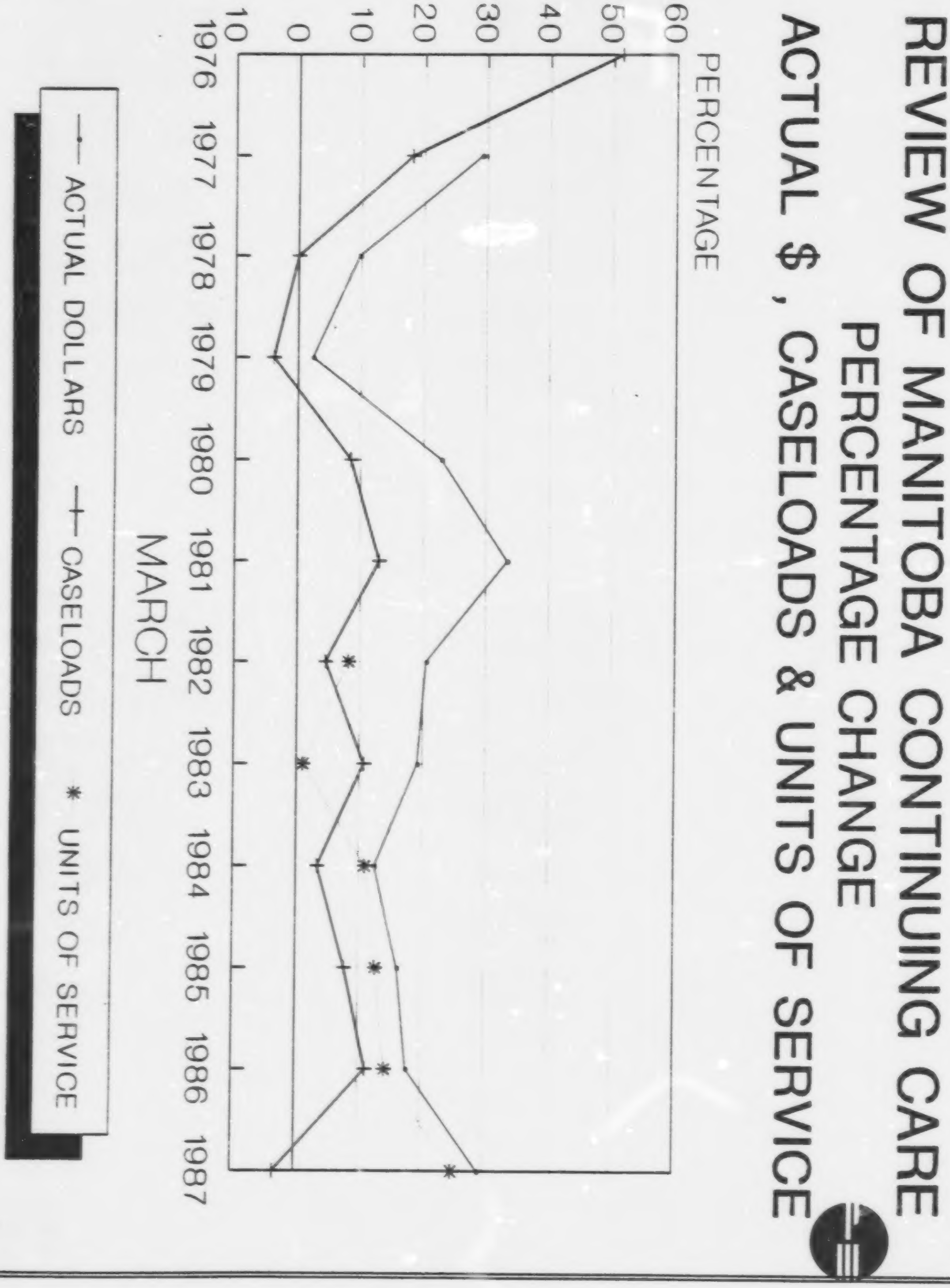


LICENSED PRACTICAL NURSES



THERAPY

Exhibit 5



REVIEW OF MANITOBA CONTINUING CARE
PERCENTAGE CHANGE
ACTUAL $, CASELOADS & UNITS OF SERVICE

The issue of whether the Program is providing too rich (or not rich enough) a level and mix of services stems, in part, from the fact that it is an open-ended program and the realization that program costs and service volumes have continued to increase at a considerable rate. Thus, an element of the richness issue is a question of control. Is there appropriate budgetary control? Is there unintended over servicing? A second element of the richness issue is one of program design. Is the Program simply, by virtue of the services it offers and its eligibility criteria, doing more for its clients than they really require? Even if there are budgetary and service controls, is the program simply offering too rich a mix and level of services?

On the first aspect of the richness issue, that of control, there are several points which support the proposition of over servicing:

- Inadequate management information. The Department has virtually no meaningful program information to assist it in managing and controlling program expenditures, types and levels of service and other items normally associated with effective budget control. Moreover, the level of current effort to obtain such information is such that the Department likely will not be in a position to gain budgetary control in the foreseeable future.

- Client survey indicates over servicing. The survey of clients (see Chapter 8 of this report) found that 33% of clients receiving nursing services did not believe that they needed the services. Also, 33% of those receiving therapy services did not see a need for them.

- Abuse of panelling to achieve richer services. In some regions, clients were being panelled inappropriately as a way of qualifying them for enriched nursing services (see chapter 16).

- Continuing Care used as "deepest pocket". The review found that the Program was perceived by community health professionals as the "deepest pocket" program, and in some regions, is being used to meet the needs of clients who cannot be covered by other programs (see chapter 14).

On the other hand, the review also noted that in three respects the Continuing Care Program compared favorably with programs in other provinces:

- Service review mechanisms better developed than other provinces. Although numerous shortcomings were identified in service controls (chapters 15 and 16 of this report), the consultants found that service controls such as caseload review and program review were better developed than those found in other Canadian provinces with which they are familiar.

- Growth in program service volume and expenditures comparable with some other provinces. The growth in program spending on the Manitoba program is not significantly above that of any other province. The average annual growth in the Home Care Assistance budget over the last 12 years was 19%. In Ontario, the figure was 24% for the ten years up to 1985. In British Columbia there was 19% growth for the nine years leading up to 1985. However, it is interesting to note that Alberta and Saskatchewan, which have set firmer limits on overall home care spending by regional or local areas, have achieved lower growth levels.

- Program management costs lower than other provinces. A smaller proportion of the total spending on Continuing Care is spent on program administration and case management (i.e., expenditures other than purchased services) than is the case for other provinces.

In 1987/88, program spending for items other than purchased services came to 17% of the total program spending. In Ontario, in 1986/87, 23% of the Home Care Program budget was spent on administration as opposed to patient care. While these figures suggest that the Manitoba program is administratively quite lean, it should be noted that administrative "leanness" can contribute to control issues if the required resources are not available to manage the program services (this issue is discussed in chapters 10 and 17).

On the second aspect of the richness issue, that of program design, the review found that, in general, the program is offering, by design, a richer set of services than most other provinces.

- Universal homemaker-only services. From the outset, the Manitoba program has provided homemaker (meals, housekeeping) services to some clients, even where no professional services are required. By contrast, only very recently Ontario has begun to introduce a homemaker-only benefit (the Integrated Homemaker Program). Further, the Ontario benefit has been accompanied by firm caps on spending by local areas as well as individual ceilings on benefits. Similarly, in British Columbia, limits have been set on the number of hours of home support service/homemaking service that individuals can receive. In British Columbia, clients are also required to make payments, according to an income geared sliding scale, to offset part of the costs of such services.

- Respite Care. The review found that the level of respite care provided under the Manitoba program compared favorably with other provinces (further data on respite care programming is provided in Appendix V).

- Highest provincial spending per capita on home care. According to Health and Welfare Canada's National Health Expenditures report, Manitoba is spending considerably more per capita on home care than other provinces. In 1985, it spent $20.38 per capita. The next highest provinces were Ontario ($15.05), Saskatchewan ($11.64) and Prince Edward Island ($11.38) [1]. The level of provincial spending on home care cannot be explained in terms of the availability of institutional resources. Ontario, for example, spends less on home care and also has fewer hospital and other institutional beds per 1,000 population. Further, according to the Forbes et al., Manitoba has a larger proportion of its elderly in institutions than any other province except Alberta [2].

- Willingness to pay. The client survey found that 13% of program clients would pay for their services themselves if service limits were imposed. Interestingly, this figure was much higher for those receiving homemaker services only.

In summary, the main conclusions regarding the richness issue are that the design of the program is relatively rich in comparison with other provinces. However, this is a feature that would be interpreted favorably by many advocates of services for the elderly. It should also be viewed in the light of the positive assessment of the program provided by the Kanes. In terms of controls, the review noted several shortcomings but it also remarked on how the program's controls compared favorably with some other provinces.

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[1] Health and Welfare Canada, National Health Expenditures in Canada 1975-1985, Ottawa, November 1987.

[2] W. Forbes, J. Jackson, A. Krauss, Institutionalization of the Elderly in Canada, Butterworth, Toronto, 1987, p. 40

It also should be noted that there may be an inverse relationship between resources spent on program staff and spending on purchased services. After a certain point, shortages of case coordinator staff can lead to poor administration of controls, lack of reassessments and, thereby, over servicing of clients. This issue is discussed more fully in chapter 17.

Demand for Home Care as a Hospital Replacement Service

Hospital bed closures, client demands to be cared for in the home, new technology and a move towards early hospital discharge all impact on community health care. Specifically, there is an increased demand for home care to deliver hospital services in the home including "high tech" care such as intravenous therapy, total parental nutrition, ventilator therapy, peritoneal dialysis, and shift nursing. This increasing demand to use home care as a hospital replacement program raises concerns for the Continuing Care Program given its current service delivery policies.

The Continuing Care Program has begun already to respond to these demands and, in Winnipeg, in particular, the Program has begun to provide increasingly complex services. While the Program is responding to an important service need, the emergence of such a hospital replacement function raises two fundamental policy questions (in addition to the increased cost of such responses):

- should the Program assume a hospital replacement service role? The Department has not addressed this question. Rather, the Program has drifted into assuming the role. Before the Program assumes this kind of a high intensity service role, a policy decision has to be made that this is the direction that the Program should take. At present, the decision has been deferred to front-line case coordinators who are accepting these cases into the Program on a case-by-case basis. In making this policy decision, the policy makers will have to weigh the pressures from consumers, hospitals and professionals to move in this direction against the likely costs of such care. Further, guidelines will need to be established as to what type of hospital replacement services and what types of patients are appropriate for in-home care. There is a danger that ever more complex and expensive cases will be sent to the community. Even the most ardent advocates of hospital replacement will recognize that there are limits to the complexity of patient needs that can be met cost-effectively through home based care.

if a decision is made to continue and even expand the Program's hospital replacement function, then another question is begged: how should the Program's service delivery policies be modified to accommodate this new function? At present, home care policies assume that home care will play a supportive role working with the family and the client themselves to meet needs. When services are provided on a hospital replacement basis, there is a requirement for a greater degree of commitment to the service. Further, a stronger service management and control infrastructure is required to guarantee the service and ensure that high standards of care are achieved. The findings in Part V of this review indicate that such an infrastructure often is lacking in the current Program.

Clearly, the Department needs to develop policies regarding the role of Continuing Care vis a vis hospital replacement services, whether such services should be supported, whether the Continuing Care Program is the best program to assume responsibility, and how Continuing Care Program service delivery practices should be modified to respond to such practices. The issue of hospital replacement services and how they are provided is likely to become increasingly pressing. Several factors can be expected to focus attention on the issue:

- pressures to continue to reduce the ratio of hospital beds to the population and decrease the length of stay and utilization rates for hospitals;

- advances in medical technology which will continue to permit more people to survive to live in conditions where they require intensive medical support, and which will continue to increase the range of services that can be provided on an in-home basis; and,

- public expectations that individuals should be served in the community rather than on an in-patient or long-term institutionalization basis.

Similar pressures for hospital replacement and complex care services in the community have been experienced in other provinces. In Ontario, the demands for such care have led to proposals to extend the range of home care benefits to include shift nursing and even to proposals for an innovative Hospital in the Home program. In Quebec, the Verdun Health Centre has been testing a new Hospitalization at Home project. In the United States, various medical plans, particularly Health Maintenance Organizations (HMOs) have shown that home care hospital replacement services can be used effectively to reduce length of hospital stay and even avoid certain admissions. Experience in other provinces also parallels Manitoba in that the demands for hospital replacement services are most prevalent in centres where there are teaching hospitals or large referral hospitals.

The hospital replacement services question represents an example of how the richness of the Continuing Care Program may have increased over time.

Housekeeping and Meal Preparation Services

As was noted earlier in this chapter, the Manitoba Continuing Care Program historically has been more generous than other provinces in terms of the provision of home maker services. The review also found evidence that some clients receiving only housekeeping services were being over serviced (see chapter 19). Clients receiving these services indicated a degree of willingness to pay for the services. Such findings suggest an opportunity to modify the scope of the program vis-a-vis housekeeping and meal preparation. (This issue is addressed more fully in chapter 19.)

There is an opportunity for the Department to facilitate further a more widespread establishment of independent not-for-profit cleaning services, meals-on-wheels and wheels-to-meals services. Such services hold the potential for relieving the Program of many of its responsibilities for providing services directly to clients. Under such special not-for-profit agencies, services would not be paid for through the Home Care Assistance budget. Most costs would be met by clients. It would also be possible to use the not-for-profit cleaning services to meet many of the needs for heavier, house maintenance type of services discussed in chapter 7, that are not currently covered by the program.

Need for a Specific Legislative Base

The Continuing Care Program operates under the broad authority of the Executive Organization Act. The Program has operated since its inception without specific program legislation. While the broad enabling features of the Executive Organization Act provides the OCC and the Department with considerable flexibility in managing and delivering the program, the review has identified a number of areas in which significant improvements in program definition and expenditure control could be achieved. These areas are:

- establishing clear statements of purposes and underlying values for the Program;
- providing definition of the types and levels of service authorized for provision by the Program. The finding that the program is being relied upon to fill service gaps in community programs which are beyond its mandate highlights a fiscal problem that the Department is experiencing;
- more precisely defining the roles, responsibilities and limits of accountability for hospitals in discharge planning;
- defining the appeal process;
- providing precise definition of eligibility for service (i.e., are children and the adult handicapped eligible?);
- defining the purpose of the panels, their membership and their processes and procedures;
- creating the provision to allow the Minister to charge and collect fees from users should it be decided now or in the future to do so;

- permitting the establishment of regulations controlling costs for services;
- defining more precisely short- and long-term care; and
- clarifying the supervision requirements of LPNs. (This likely will require parallel amending legislation to the Licensed Practical Nurses Act).

The normal requirements for stewardship of a program that costs in excess of $40 million (i.e., the Home Care Assistant Budget plus the respective Program costs covered by the Community Health operating budget) demand such a base. In addition, other Canadian provincial jurisdictions providing home care have placed home care in special legislation (i.e., Saskatchewan) or under sections of their medicare legislation (i.e., Alberta and Ontario).

Therefore, the Department should develop a specific legislative base to address program definition, program accountability and expenditure control.

Summary findings for this chapter are set out in Exhibit 6, following.

Exhibit 6

SUMMARY FINDINGS: PROGRAM POLICIES AND DIRECTION

ISSUES/CONCERNS	IMPLICATIONS	OPTIONS/SOLUTIONS
1. Increasing demands to use Home Care as hospital replacement service in conflict with service delivery policies	. shift to "high-tech" nursing care . lack of capacity of continuing care program excepting VON) to deliver replacement services, therefore, replacement services not available to all clients outside Winnipeg and long-term clients in Winnipeg . demands inconsistent with program principle of providing support services	review need for hospital replacement services with view to: a) establishing justification b) determining whether continuing care should assume responsibility
2. Opportunities for CCP to decrease service levels for housekeeping and meal preparation services	. many clients are willing to pay . evidence of over-servicing . Manitoba more generous than other provinces	. emphasize the development of not-for-profit house cleaning corporations . facilitate further development of independent meal services agencies
3. Need for a legislative base	. specific Program definition . expenditure control and accountability	. specific legislation

PROGRAM POLICIES AND DIRECTION - RECOMMENDATIONS

1. IN CONSULTATION WITH MHSC AND WITH INDIVIDUAL HOSPITALS, THE OFFICE OF CONTINUING CARE SHOULD REVIEW THE NEED FOR COMMUNITY-BASED HOSPITAL REPLACEMENT SERVICES (I.E., SERVICES PROVIDED ON AN IN-HOME BASIS THAT OFFER A SUBSTITUTE FOR HOSPITAL IN-PATIENT CARE) AND DETERMINE WHETHER THE CONTINUING CARE PROGRAM SHOULD ASSUME RESPONSIBILITY FOR SUCH SERVICES.

2. THE DEPARTMENT SHOULD ADOPT AN EXPANDED LONG-TERM STRATEGY TO FACILITATE THE DEVELOPMENT OF INDEPENDENT NOT-FOR-PROFIT CLEANING SERVICES IN ALL COMMUNITIES (WHERE GEOGRAPHICALLY FEASIBLE) ACROSS THE PROVINCE. THIS EFFECTIVELY SHOULD TAKE THE PROGRAM OUT OF THE BUSINESS OF PROVIDING HOUSE CLEANING SERVICES. CONSIDERATION ALSO SHOULD BE GIVEN TO INCLUDING HOUSE MAINTENANCE SERVICES ALONG WITH INDEPENDENT NOT-FOR-PROFIT CLEANING SERVICES.

3. THE GOVERNMENT SHOULD PREPARE LEGISLATION FOR THE CONTINUING CARE PROGRAM THAT DEFINES THE PURPOSE, SCOPE AND MANDATE OF THE PROGRAM.

5. PROGRAM SCOPE AND MANDATE

BACKGROUND

The review was directed to focus on the definition and appropriateness of the Program's scope and mandate.

DESCRIPTION

The Continuing Care Program provides a continuum of health care for individuals living at home who require supportive health care; discharged from hospitals who require professional medical and supportive home care; and, requiring placement into a care facility. Consequently, the program provides services to support the provision of care at home; and, assessment for facility care placement. These services are designed to meet seven program objectives outlined in the policy guidelines. The objectives are discussed in detail in chapter 6.

FINDINGS

Two major areas of concern relative to Program scope, mandate and objectives were identified in the review:

- the adult disabled place unique service demands on Continuing Care Program that often conflict with program policies; and,

- there is a lack of emphasis in the program objectives on promoting client independence.

Each of these findings is discussed below and summarized in Exhibit 7, at the end of this chapter.

Adult Disabled within Continuing Care Program

The adult disabled place unique service demands on the Continuing Care Program that are in conflict with program policies:

. demand for guaranteed service related to the absence of primary care givers. The adult disabled rely on home care attendants/orderlies to assist with personal care and dressing at regularly scheduled intervals to meet employment demands;

. demand for control of service. Adult disabled want assistance that meets their and not the Continuing Care Program's schedule (e.g., night bedtime care);

. demand for specialized services not permitted by Continuing Care Program guidelines. The cradle-lift and two-man lift are two procedures not supported by the Continuing Care Program but necessary for transferring adult disabled clients; and,

. demand for 24 hour emergency back up services from program. Bladder catheter blockage and falls are two instances when the adult disabled require emergency assistance from personal care attendants, not emergency care from hospitals.

There also is a concern among the adult disabled that they should not be served under a program they perceive exists for the ill and the infirm. They require assistance with activities of daily living, not health care. The demands placed by adult disabled can and do result in:

. tensions between program staff and the disabled client groups especially centering around service delivery issues;

. services failing to meet client needs fully (e.g., emergency back up care);

- staff and direct service workers departing from program policies (e.g., unauthorized lifts) which potentially increase liability risks; and,

- service abuse and related costs (e.g., personal care attendants and clients scheduling calls and not being available.

OPTIONS

It is suggested that the findings and recommendations in previous studies and task forces (e.g., Task Force on the Young Disabled Report to the Minister of Health - January 1984) should be assessed with a view to implementing appropriate recommendations.

It is further suggested that consideration be given to alternative administrative structures to cover the provision of services to the adult disabled such as the:

- establishment of a special service stream for the disabled within Continuing Care Program, one with distinctive program policies addressing the needs of the disabled; or,

- establishment of a separate program for the disabled within community health; or,

- establishment of an independent authority dedicated to servicing the disabled.

Alternate models for service delivery might include:

- services purchased from direct service workers by central program or agency (e.g., home orderlies/home care attendants); or,

- services purchased from a contracted service agency by central program/agency (e.g., 1010 Sinclair, HIDI, Luther Home); or,

- providing clients with special allowance to purchase services independently (e.g., a voucher system).

In their paper, the Kanes review this issue and conclude that

> "To the extent the two groups (the elderly and the disabled) are both likely to need personal care and homemaking services, it is inefficient to separate the clientele by age. Indeed, it may be that when case coordinators work with both younger and older clientele, they gain an appropriate corrective tendency toward paternalism with regard to the elderly."

The findings of the review support the position taken by the Kanes that for reasons of service efficiency, home care services for the adult disabled should be administered by the same program as those for the elderly.

Lack of Emphasis on Client Independence

In discussing program objectives continuing care staff spoke of preventing institutionalization, keeping clients at home, and relieving family stress. While these statements can be linked directly to the seven program objectives, the absence of promoting client independence was evident, specifically in relation to the elderly within the program. There appeared to be an overwhelming need to "help the elderly client" by putting in services rather than "helping the elderly client help himself/herself".

The Kanes also draw attention to this point:

> "Long-term care benefits keyed to functional disability are highly desirable, with one proviso: the system must be able to detect and eliminate remediable causes of functional impairment. Providing services to compensate for impairments that could be eliminated in the first place is neither humane nor cost-effective. On this

> point, we doubt that Manitoba has yet achieved optimum communication and working arrangements between case coordinators and the primary care physicians (or geriatricians, when available), or optimum links between the acute-care hospital and chronic care either in the community or in a facility."

The lack of program focus on client independence results in:

- case coordinator authorizing services with inadequate commitment to achieving client independence;
- missed opportunities to enhance client independence; and,
- clients staying on the program an unnecessarily long time due to service dependence.

OPTIONS

It is suggested that program objectives be reviewed with a view to increasing emphasis on client independence. As well, case coordinators should be sensitized to the concerns of client independence.

Program Scope and Mandate review findings are summarized in Exhibit 7, following.

Exhibit 7

SUMMARY FINDINGS: PROGRAM SCOPE AND MANDATE

ISSUES/CONCERNS	IMPLICATIONS	OPTIONS/SOLUTIONS
1. Adult disabled place unique service demands on CCP, that are in conflict with program policies	. tensions between program staff and disabled client group . services failing to fully meet client needs	. assess findings and recommendations in previous studies and task forces (e.g., task force Report to Minister of Health, January 1984 on the Young Disabled)
. demand for guaranteed service related to absence of primary care givers	. staff and direct service workers departing from program policies	. give consideration to alternative administrative structures:
. demand for control service	. liabiity risks . service abuse and related costs	- establishment of special service stream for the disabled within the CCP OR
. demand for specialized services not permitted by CCP guidelines . cradle lift . 2 man lifts		- establishment of a seperate program for the disabled within community health OR
. demand for 24 hour emergency back up services from program		- establishment of an independent authority dedicated to serving the disabled
. concern that adult disabled should not be served under a program perceived as existing for the ill and infirm		. give consideration to alternative models for service delivery: - services purchased from direct service workers by central program or agency (e.g., Home Orderlies Home Care Attendants)

Exhibit 7

SUMMARY FINDINGS: PROGRAM SCOPE AND MANDATE (cont'd)

ISSUES/CONCERNS	IMPLICATIONS	OPTIONS/SOLUTIONS
		- services puchased from contracted service agency by central program/agency (e.g., 1010 Sinclair, HIDI, Luther Home) - provide clients with special allowances to purchase services independently (i.e., voucher system)
2. Lack of emphasis in program objectives for promoting client independence rather than focus on preventing institutionalization	. case coordinator emphasis on putting in services with inadequate commitment to achieving client independence . opportunities to enhance client independence missed . clients staying on program unnecessarily long time	. review objectives with view to increasing emphasis on client independence . ensure case coordinators are sensitized to concerns of client independence

PROGRAM SCOPE AND MANDATE - RECOMMENDATIONS

1. THE DEPARTMENT SHOULD EXAMINE THE FINDINGS AND RECOMMENDATIONS OF PREVIOUS STUDIES AND TASK FORCES ON SERVICES FOR THE ADULT DISABLED. IT SHOULD SELECT AND IMPLEMENT AN APPROPRIATE ADMINISTRATIVE STRUCTURE AND DELIVERY MODEL TO SERVE THIS POPULATION. IT IS RECOMMENDED THAT HOME CARE SERVICES FOR THE ADULT DISABLED CONTINUE TO BE ADMINISTERED THROUGH THE CONTINUING CARE PROGRAM.

2. THE OFFICE OF CONTINUING CARE SHOULD REVIEW PROGRAM OBJECTIVES WITH A VIEW TO PLACING GREATER EMPHASIS ON ACHIEVING CLIENT INDEPENDENCE. EFFORTS SHOULD BE UNDERTAKEN TO SENSITIZE CASE COORDINATORS TO THIS CONCERN.

6. PROGRAM EFFECTIVENESS

BACKGROUND

The review was to answer questions concerning the effectiveness of the Program in relieving pressure on families, facilitating deinstitutionalization and improving client health outcomes. At the outset of the review, it was recognized that to address these questions fully would require an elaborate research undertaking that was beyond the scope of this study.

This chapter is organized into four topic areas:

- Program Objectives;
- Cost Effectiveness of Home Care as an Alternative to Institutional Care;
- Program Monitoring and Evaluation, including Program Outcome; and
- Quality Assurance.

Each topic is described below.

PROGRAM OBJECTIVES

Description

Program objectives provide the basis for judging the effectiveness of a program. Efforts to monitor or evaluate program effectiveness should involve examining the extent to which the Program contributes to the achievement of its objectives. For objectives to provide a useful basis for measuring effectiveness, they should represent statements of what it is that the Program is intended to accomplish. Objectives that simply state what the program does, rather than what it should accomplish, are of no value in assessing effectiveness.

The objectives of the Continuing Care Program as outlined in the Program manual are:

1) To provide an assessment for care which determines whether a person's care needs can be met appropriately at home or whether the person requires an institutional setting to meet care needs;

2) To develop and provide services in the home setting as a viable form of care;

3) To provide services at home as an alternative to institutional care for those for whom care at home is most appropriate;

4) To facilitate placement into care facilities for those for whom care at home is not appropriate;

5) To relieve excess stress on family members and, in so doing, prevent the breakdown of a desirable living arrangement and/or the health of the person/persons providing care;

6) To prevent the premature, expensive or unnecessary placement of persons in care facilities (including hospitals) and thus prevent the unnecessary building and utilization of institutional facilities; and,

7) To continuously evaluate the impact of the Continuing Care Program on the target population and other Health Care delivery systems.

Findings

Objectives (1) to (4), and objective (7) provide little insight into what the Program is intended to accomplish and as such are of minimal value in assessing program effectiveness. They are simply statements of what the program does, not of intended outcomes. Objectives (5) and (6), on the other hand, represent clear statements of program intent, and could serve as an appropriate focus for effectiveness monitoring and evaluation. Interestingly, these two objectives make little reference to the benefits of the Program to the client. Objective (5) concerns benefits to care givers and objective (6) addresses benefits for the health care system. In chapter 18, we raise the question of whether the program should not also have objectives that address concerns for maintaining and improving the clients' physical and social well being. The plain fact is that the Program has no clear, measurable, stated objectives concerning health status, deinstitutionalization or of the type of client it is to serve.

COST EFFECTIVENESS OF HOME CARE AS AN ALTERNATIVE TO INSTITUTIONAL CARE

Description

The history of the development of long-term care programs in Canada, as well as other jurisdictions, has been marked by arguments justifying the introduction of such services on the grounds that home care will serve as a cost-effective alternative to institutional care. It is hard to believe that the introduction of home care was seen by its advocates and by political decision makers only in terms of cost savings to the system. Nevertheless, efforts to justify the introduction of such programming to central funding agencies in government have, understandably, focused almost exclusively on such cost saving arguments. Kane and Kane in their discussion paper for this report (see Addendum) refer to this line of justifying home care services as the "alternatives mentality" (pp.11-15).

Findings

There is a substantial body of research evidence that casts doubt on the "alternatives" justification for home care programming. After reviewing the research literature, in particular the results of the many long-term care demonstration projects, Kane and Kane conclude:

> "... there was an impressive consistency in the findings: Many patients could be managed in the community, but doing so did not produce a cost effective alternative to nursing homes."

They go on to conclude:

> "These findings do not mean that community care is not a worthwhile goal. Rather, they suggest that community care should be pursued as an end in itself when it is the mode preferred by the citizenry. The lessons of the United States demonstration projects come in the form of cautionary notes. They show the fallacy of evaluating the Continuing Care Program by its overall cost-effectiveness as a substitute for care in personal care homes; this could only be achieved by limiting home care to persons willing to enter a nursing home--an absurd criterion."

The Program objectives touch on the "alternatives" theme when they state that the program is intended to prevent premature placement or over stay in care facilities. One of the primary impetuses to establishing the Continuing Care Program was to offset use of personal care homes. There is no evidence that such an offset has occurred. In addition, there is evidence that the cost of the alternative to care facilities is substantially higher in many instances. Interest in the extent to which the Continuing Care Program can be justified continues to be a theme in policy discussions around the Program. The question is raised again in the terms of reference for this review.

The Department should not fall into the trap of trying to justify the program as a cost-effective institutional alternative. Extensive research would tend to contradict this position. Rather, the Program should be justified primarily as a Program in its own right that meets the health and support needs of people living in the community.

While it may not be possible to justify Home Care solely on the basis of it being a cost-effective alternative to institutionalization, it appears to have become established in much of the public's mind as a valuable service in its own right, one that is an essential element in the range of human services supported by the taxpayer.

Although this review did not include the rigorous evaluation research required to provide definitive conclusions regarding the extent to which home care was caring for people who would otherwise have been in institutional care, our survey of program clients did provide some interesting insights:

> 37% of clients receiving services under the Program indicated that they would not have been able to continue living in their current housing if Home Care services were not available. Of these, 44% said they would have gone to a personal care home, 17% would have gone to an Elderly Persons Housing (EPH) Unit, 9% would have moved to the home of friends or family and the rest did not know what they would do or did not state it.

Clearly, these findings represent the subjective response of clients. It is difficult to judge what would occur actually in the absence of home care services. However, it should be noted that the level of utilization of personal care homes or elderly persons housing units would not automatically rise if the Continuing Care Program were withdrawn. The utilization of such institutional services is constrained by their supply. There is, nevertheless, a plausible argument that without Home Care there would be a number of individuals (well less than half of those served) in need of services that could only be met through either an increase in institutional beds or the re-establishment of Home Care.

The relationship between home care and acute care has already been discussed (pages 22 to 25). Home care is increasingly serving as a substitute for hospital care. In many respects, this neither reflects the original intent of the program nor does it reflect a new area of services that the program has identified and deliberately sought to address. Rather, the program has had to react to increased discharge and follow-up pressures from the hospital sector. Such pressures have arisen from shorter lengths of acute hospital stays, more stringent admission criteria, and increasing use of ambulatory care (including ambulatory surgery). While home care clearly has the potential to serve in a hospital replacement capacity for some acute patients, it is important to reiterate that from the program's perspective, this has occurred less by design and more by the necessity of reacting to an emerging demand for care.

There is a body of research from other jurisdictions on the cost effectiveness of home care as an alternative to acute hospital care. The findings indicate that home care can provide a cost effective alternative for selected types of care and treatment needs. However, it is difficult to generalize these findings to Manitoba because of differences in services and cost structures between Manitoba and the jurisdictions in which the research was carried out, and because of changes in medical technology and practice that may have occurred since the research was carried out.

PROGRAM MONITORING AND EVALUATION, INCLUDING PROGRAM OUTCOMES

Findings

There are little data available to assess program effectiveness and service performance. The Program does not have any established mechanisms for gathering ongoing data regarding the accomplishment of its objectives. Such data would be useful in two ways:

- providing a basis for holding the program accountable for achieving its intended effects; and
- providing information that could assist program managers in identifying improvements in the program and services.

The absence of any data systems that address clients' health status, makes it difficult to offer any opinion vis a vis the review terms of reference on client health status (item #1). Although some health status data are captured in the Program's assessment forms, they are not gathered in a manner that would support research purposes and they are not reported.

Options

There are two types of strategy that can be followed in gathering information on program effectiveness:

- conducting periodic evaluations. Such evaluations draw on applied social research techniques to measure the achievement of program objectives. They might entail surveys of clients and family members to determine program impacts; and

- establishing an ongoing performance monitoring system. This would entail routinized collection of data that shed light on program effectiveness. Such a system could be based on data that would be collected routinely at assessment, reassessment and discharge points in the program process. This type of system would be accompanied by standardized reporting formats to meet the information needs of case coordinators and program management.

Until the program objectives are clarified to reflect fully what it is that Program is intended to accomplish, it is difficult to provide more specific direction on how such periodic or ongoing evaluation processes could be structured.

There is a need for the program to institute procedures that routinely measure client health status. It should be recognized that such procedures would probably not offer a means of definitively attributing changes in client health status to the program. For many clients with chronic and terminal illnesses, positive health status impacts could simply entail alleviating symptoms, facilitating better coping and slowing the progression of the illness. At an aggregate level, however, information on client health status would be useful for monitoring the health needs of program clientele as a whole, including changes in such needs over time and variations in needs among regions. Such information would be useful for program planning.

A promising approach for measuring home care clients' health status will be available shortly from Alberta. The Alberta Coordinated Home Care Program, with the assistance of Price Waterhouse, Management Consultants, is very close to finalizing a process for measuring client outcomes for home care. The Alberta approach entails an outcome measurement tool that addresses a variety of outcome areas including health. These areas are as follows:

I Physiological Health Status
  - Blood Pressure
  - Pulse
  - Blood Glucose
  - Weight
  - Skin Care
  - Foot Care
  - Wound Healing - Surgical
  - Wound Healing - Skin Ulcer
  - Edema

II Pain Management

III Symptom Control
  - Nausea
  - Loss of Appetite
  - Fatigue
  - Bowel Irregularities
  - Bladder Problems
  - Sleep
  - General Weakness
  - Stiffness
  - Cough
  - Dizziness
  - Respiration

IV Activities of Daily Living

V Activities of Household Management

VI Satisfaction with Services - Family

VII Satisfaction with Services - Client

This tool is designed to be administered at the admission of the clients to the program, at the time of follow-up visits and on discharge. It can be used in conjunction with a process for setting goals for each client. The tool includes several measures that have been taken, or adapted, from instruments developed and tested in other jurisdictions.

No other province or American jurisdiction that we have examined has developed a comparable outcome measurement tool for home care. Although the intake assessment tools for several provincial home care programs gather relevant health data, we are unaware of any programs outside Alberta that routinely measure health status on an ongoing basis, or at discharge.

The Alberta outcome measurement tool represents an opportunity for the Manitoba program to take advantage of development work done in another Canadian jurisdiction. However, if the Alberta tool were to be adopted in Manitoba, allowance would have to be made for differences between the two provincial programs. The Alberta program places heavier emphasis on medical conditions in establishing individuals' need for the program and does not give as much weight to social conditions as the Manitoba program.

It should also be recognized that there are a large number of alternative approaches to measuring health status among the elderly and long-term care population. Specific tools include:

For Physical Health:

Cornell Medical Index
Health Index
Patient Classification Form: Section III: Impairments
PACE II: Medical Data Section
OARS: Physical Health Section, Questions 27 to 55
Cumulative Illness Rating Scale

For Activities of Daily Living:

Pulses
Index of ADL
Kenny Self-Care Evaluation
Barthel Index
Barthel Self-Care Ratings
Range of Motion
PACE II: Physical Functioning
OARS: Physical ADL
Functional Health Status Index for Institutionalized Elderly (ADL-A)
Rapid Disability Rating Scale

For Instrumental Activities of Daily Living:

Rosow Functional Health Scale
PGC Instrumental Activities of Daily Living
PGC Instrumental Role Maintenance Scale
PACE II: Ability to Carry Out IADL
OARS: Instrumental ADL Questions 56 to 62
Caro Functioning for Independent Living Scale (FIL)
PGAP Functional Assessment Instrument

These instruments are all reviewed in Kane and Kane, *Assessing the Elderly*, (Lexington: 1981), pages 25 to 68.

However, most of these instruments are not appropriate to be included in day to day program data collection since they were designed as research instruments and generally presume a high level of training of those administering them in order to ensure that they are consistently applied as intended.

QUALITY ASSURANCE

Description

The major elements of a Quality Assurance Program include structure, process and outcome standards, and monitoring, reporting and evaluation mechanisms.

The three types of standards are outlined below.

Structure standards deal with administrative structures to support and direct client care. These include documented:

- goals and objectives for the program;
- organization and administration plans to accomplish Program functions;
- policies and procedures to provide staff with clear direction on the scope and limitations of their functions and responsibilities;
- standards for the direction and staffing necessary to provide care;
- standards for equipment and supplies used in care provision; and,

. standards for education of staff and clients.

Process standards deal with the appropriateness and completeness with which client care is provided. In Continuing Care, these standards should be designed to cover the following important care processes: intake, assessment, care plan development, care provision, reassessment, and panelling.

Outcome standards deal with the outcome(s) of care and in Continuing Care can include health status, placement into care facilities, and relieving family stress.

Mechanisms to monitor the adherence to program standards should be in place. Further, mechanisms to report standards compliance must be available and, finally, there must be a mechanism to ensure the evaluation of action taken to correct less than standard compliance.

Findings

While further ahead than the Ontario Home Care Program in terms of Quality Assurance, the Continuing Care Program has fallen short in establishing comprehensive structural, process and outcome standards.

Again, while the Continuing Care Program has established some structures and process standards (program objectives, program policies and procedures, reassessment guidelines, care planning format, etc.), there is a need for a more comprehensive approach to standard development in these two areas. Further, there is a need to establish outcome standards. The impact of service limits or any change in service delivery will not be understood if measurable outcome standards do not exist. It is recognized that the development of comprehensive service standards and outcome measures is, potentially, a major undertaking. One option to fulfilling this need would be to explore the possibility of developing these as part of a broader federal-provincial project.

A core and key feature of the Program since its inception has been the emphasis on review - case, caseload and program review.

Case review refers to the process undertaken every three months by the case coordinators to re-assess client needs and subsequent service needs.

Caseload Review focuses on the management of program service delivery by reviewing a Continuing Care caseload, at least annually, to examine one or more program components (e.g., assessment, reassessment, eligibility, care planning, case coordination, resource utilization and so on). This process usually is attended by case coordinators, program supervisors, Regional Continuing Care Coordinators and, where possible, Office of Continuing Care staff.

Program Review is an overview of program delivery in a region and/or agency to examine the extent to which program objectives are being met. The participants include the Director of the Office of Continuing Care, Regional Director, Regional Continuing Care Coordinator and others deemed necessary.

In each review a report outlining findings is generated and appropriate action requested.

While some monitoring and reporting mechanisms exist, they are not fully effectual due to the lack of comprehensive standards. Take program review as an example.

The purpose of program review as mentioned previously is to:

. review the management of the Program in the region;

. review the quality of program delivery in the region, including panel structure and placement process;

. review implementation and interpretation of program policy; and,

. review directions for further program development.

If comprehensive standards do not exist for program management (e.g., number of supervisors), or for panelling (e.g., membership), or, for program implementation (e.g., liaison with outside agencies), monitoring program performance across the province is extremely difficult.

Responsibility for such a quality assurance system could be located in the Office of Continuing Care. This would help to ensure that service standards and practices are applied consistently across all regions. It would address the concern that a decentralized regional delivery structure may be interpreted and delivered differently from one region to another, and that such variations might compromise service quality. A comprehensive quality assurance program located in the Office of Continuing Care would help to ensure high, uniform standards of service across all regions.

The Kanes arrived at a similar conclusion, although they suggest that the absence of quality assurance procedures might not have as severe an effect in Manitoba as would be the case in U.S. jurisdictions:

> "... it seems that the quality assurance mechanisms in Manitoba, particularly in the Continuing Care sector, are rather rudimentary; indeed, the data generated in the case and program reports do not permit an effective surveillance. Quality assurance in home care tends in general to be under-developed in other jurisdictions as

> well though it is an area presently coming under scrutiny. Manitoba does have the advantage that its scale of operation (given a provincial population that barely exceeds one million) permits program officials to have considerable personal knowledge of the professional and bureaucratic actors; the program is characterized by better will than in the United States where adversarial relationships between providers and payers and across levels of government often arise."

Summarized in Exhibit 8, following, are the findings discussed in this chapter.

Exhibit 8

SUMMARY FINDINGS: PROGRAM EFFECTIVENESS

ISSUES/CONCERNS	IMPLICATIONS	OPTIONS/SOLUTIONS
1. Some program objectives do not reflect what the program is intended to accomplish	- objectives do not provide a valid basis for measuring program effectiveness	- review Program objectives with view to identifying the intended effects of the program
2. Program rationale not fully supported by research findings from other jursidictions	- unrealistic expectations of program	- need to reexamine program rationale and explore alternative approaches to justifying the program
3. Lack of information on program effectiveness	- limited data on which to plan program improvements - limited basis on which to hold program accountable for achieving its objective	- develop mechanisms for gathering on-going data on program effectiveness
4. Lack of a comprehensive quality assurance program	- limited information on service quality upon which to identify enhancements in program services.	- develop a comprehensive quality assurance program

PROGRAM EFFECTIVENESS - RECOMMENDATIONS

1. THE OFFICE OF CONTINUING CARE SHOULD RE-EXAMINE THE PROGRAM'S OBJECTIVES WITH A VIEW TO ENSURING THAT THEY FULLY REPRESENT WHAT THE PROGRAM IS INTENDED TO ACCOMPLISH. HAVING ESTABLISHED APPROPRIATE PROGRAM OBJECTIVES, THE OFFICE OF CONTINUING CARE SHOULD INTRODUCE MECHANISMS TO MONITOR THEIR ACHIEVEMENT. THE DEPARTMENT SHOULD APPROACH THE ALBERTA DEPARTMENT OF COMMUNITY HEALTH WITH A VIEW TO ADOPTING MEASURES THAT THEY HAVE RECENTLY DEVELOPED FOR THE HOME CARE OUTCOME MEASUREMENT TOOL.

2. THE OFFICE OF CONTINUING CARE SHOULD DEVELOP A COMPREHENSIVE QUALITY ASSURANCE (QA) PROGRAM. OVERALL RESPONSIBILITY FOR THE QUALITY ASSURANCE PROGRAM SHOULD BE LOCATED IN THE OFFICE OF CONTINUING CARE.

PART III : PROGRAM CLIENTS

INTRODUCTION

This section of the report presents a description of the program clients and findings on clients' perceptions of the Program. Most of the findings in this section are derived from the survey of program clients (n-1001), although some are derived from a review of client files in three regions and within VON (n-80). Regional variations will be presented where appropriate.[3] A full discussion of regional variations is presented in Appendix N.

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[3] Because expected cell frequencies were less than 5 in more than 20% of the expected frequencies; statistical significances using the chi-square test of independence were not reported.

7. CLIENT PROFILE

DESCRIPTION

Exhibit 9, following, depicts the Program's growth in age groups (0-18, 19-64, and 65+) between 1976 and 1987. Data below are derived from the client survey.

The Continuing Care Program is serving mainly an elderly client population. Seventy-nine percent of the clients are over 65 years of age and 20% of the clients over 65 years of age are over 85 years of age. Less than 21% of the clients are under the age of 65. Westman, Parklands, Winnipeg South and Winnipeg West Central regions have a higher percentage of clients over 85 years (24% for each of the four regions). Central region has a higher percentage of young clients (23% were 19-64 years of age), and very old clients (27% clients were over 85 years of age). Short-term care clients in Winnipeg, in contrast to the other regions, were young (46% clients were less than 65 years of age).

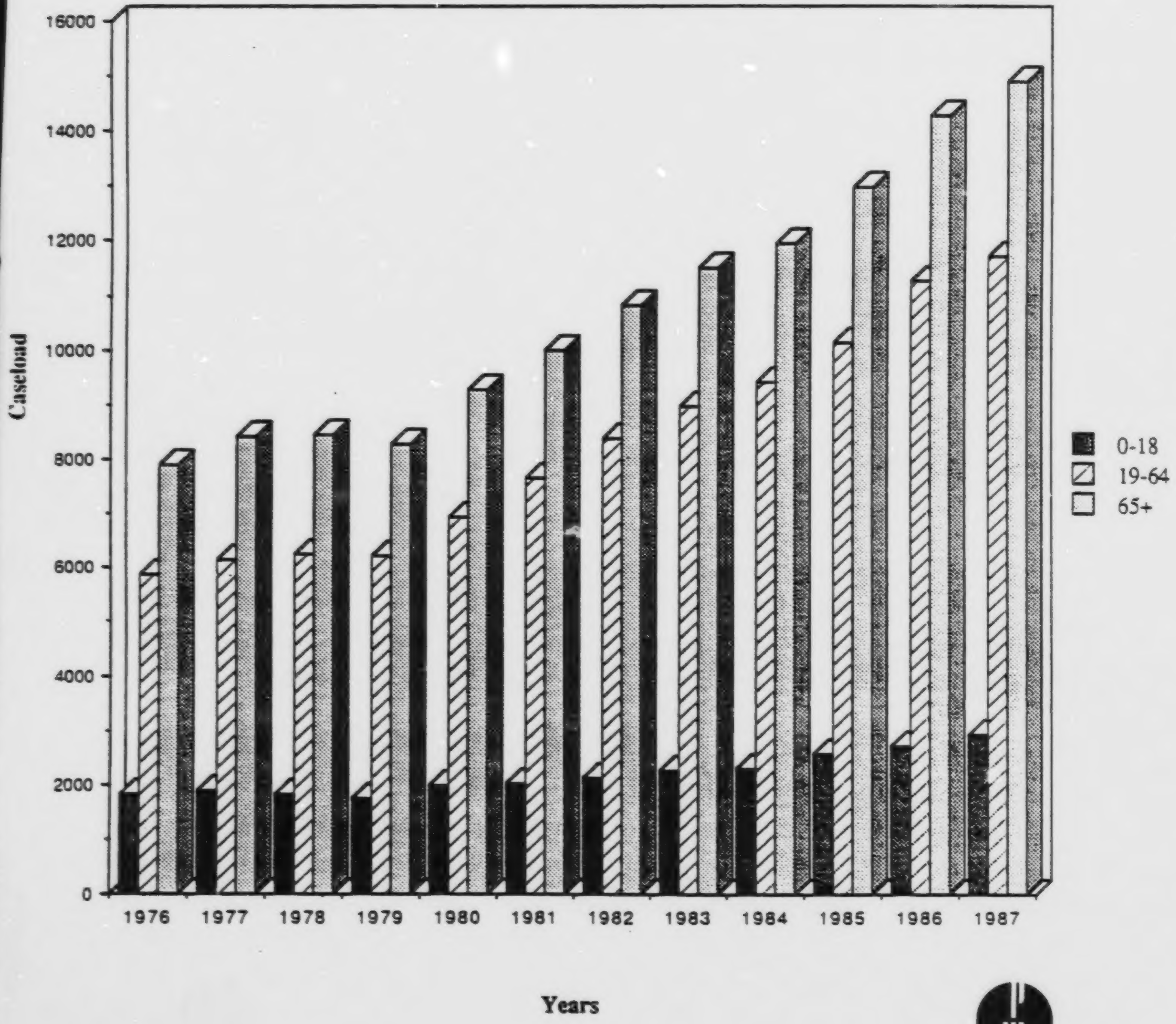
Sixty-eight percent of the client population are female. However, Norman, Thompson, Winnipeg North and Winnipeg South regions have a higher percentage of female clients (75%, 80%, 73%, and 72% respectively). As for marital status, 46% of the clients are widowed with Parklands and Norman regions having a higher percentage of widowed clients (58% each). Approximately 36% of the clients are married, 12% are single and 5% are divorced or separated. A greater percentage of short-term care clients in Winnipeg, in contrast to the 10 regions, are single (23%).

Eighty-four percent of the clients speak English. Eastman, Central, and Winnipeg North regions have a higher percentage of non-English speaking clients (43%, 29%, and 23% respectively). Ukrainian (4.8%), German (4.5%), and French (3.3%) are the next most frequently spoken languages.

Exhibit 9

Maximum Home Care Caseload by Age Group

March 1976-1987



Fifty-five percent of the clients reside in a house, while 21% live in an apartment and 22% live in an Elderly Person's Housing Unit. Westman, Central, Interlake, Parklands and Thompson region clients as well as short-term care clients in Winnipeg all have a higher percentage of clients residing in houses (66%, 69%, 71%, 68%, and 100% respectively). In contrast, the Winnipeg regions have a greater percentage of apartment and housing unit dwellers (43% in Winnipeg North, 60% in Winnipeg South and 64% in Winnipeg West Central). Fifty-one percent of the clients live alone, while 30% live with their spouses and 18% live with relatives/ friends. Westman, Eastman, and Interlake regions have a lower percentage of clients living alone (47%, 37%, and 42% respectively).

Sixty-three percent of the individuals living with program clients are healthy, and 35% are not healthy according to the survey respondents. Interlake and Parklands regions have a higher percentage of non healthy individuals living with the client (46% and 45% respectively). Thirty percent of the individuals living with program clients work outside of the home and 70% do not. Of the 30% of individuals living with the client and working outside of the home, 77% work the day shift and 19% work split shifts.

Forty-nine percent of the clients live in the same city as their closest adult relatives, an additional 16% live in the same household/building, and another 10% live within three blocks of the relatives' residence. Sixteen percent of the clients have relatives living in Manitoba but not in the same city, and 8% do not live in the same province as their closest relatives. Westman, Central, Interlake, and Parklands regions have a greater percentage of clients without relatives in their home town/city (49%, 44%, 29%, and 39% respectively).

Appendix O contains pie charts and tables displaying the data described above.

IMPLICATIONS

The age, sex, marital status, language, housing, family support, living arrangements, and health and employment status of household members of clients have implications for service provision. Regional variations also must be considered when service needs are being identified. While it is not suggested that Continuing Care respond to all client needs, service needs associated with the above variables are presented to identify demands/potential service policy issues and/or skill requirements of staff. The client profile and potential service implications are summarized in Exhibit 10 at the end of this chapter.

Age

Initially, the Continuing Care Program was established to meet the needs of an elderly population. The basic client profile, therefore, has not changed in thirteen years. Elderly clients account for 79% of the client population. This figure was higher in Westman, Parklands and the Winnipeg Regions. It is projected by Statistics Canada that the age group 85 years and over in Manitoba will increase 70% in the next twenty years. The following data on needs of those 75 and above may have implications for future service requirements and demands.

Statistics Canada reported the proportion of population 75 years of age and over requiring some help with selected activities.[4] These activities and proportions for both sexes are:

-	yard work	64%
-	heavy housework	46%
-	grocery shopping	33%

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[4] Statistics Canada, General Social Survey Analysis Services, Health and Social Support, 1985

-	meal preparation	17%
-	managing money	12%
-	light housework	9%
-	personal care	7%

Currently, home care services do not include yard work, heavy housework, grocery shopping or managing money. The high percentage of individuals requiring assistance with these activities suggests the need to review how these needs will be met in the future.

Sex

The traditional female role involved house cleaning and child rearing responsibilities,not financial management or household maintenance. Statistics Canada 1985 reported the proportion of female population over 55 years of age requiring some help with selected activities.[5] These activities and proportion for males and females are as follows:

		Female	Male
-	yard work	46%	18%
-	heavy housework	22%	20%
-	grocery shopping	16%	8%
-	meal preparation	5%	10%
-	managing money	6%	3%
-	light housework	3%	3%
-	personal care	3%	2%

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[5] Ibid.

Further, females will spend approximately 2.5 years longer than males with some degree of long-term disability not requiring institutionalization.[6] The major health problems of Canadian females with activity limitation in the household are[7]:

-	limb and joint disorders	18%
-	arthritis/rheumatism	13%
-	heart disease	10%

These conditions emphasize the need to ensure that yard work and heavy housework services are available to the growing elderly female population.

The proportions of males and females 75 years of age and over requiring some help with selected activities are even greater[8], and are as follows:

		Female	Male
-	yard work	82%	40%
-	heavy housework	49%	43%
-	grocery shopping	39%	23%
-	meal preparation	13%	24%
-	managing money	14%	8%
-	light housework	8%	10%
-	personal care	7%	---

Again the need for the provision of support services is highlighted for the rapidly escalating elderly client population.

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[6] R. Wilkins and O. Adams, Healthfulness of Life, Institute for Research on Public Policy, 1983, pp. 84

[7] Ibid., pp. 45

[8] Statistics Canada, op.cit.

Marital Status

Forty-six percent of the clients surveyed were widowed. The percentage was higher in Parklands and Norman Regions. The actual time since their spouse's death is unknown. However, there may be a need for:

. counselling services to assist clients to cope with the grief and loss of loved ones; and,

. social activities to decrease solitary existence.

The lack of social workers in the Regions where a high percentage of clients are widowed is cause for concern given that without these social services, it is possible that premature institutionalization will occur as a result of physical and psychological deterioration. There is evidence to suggest that health declines with social isolation.[9]

Language

Eighty-four percent of the clients speak English. There is a need to ensure written materials are available in English, and that direct service workers and program staff communicate in English. The regions with a high percentage of non-English speaking clients have different needs.

Housing

The clients are almost evenly divided between living in houses (55%) and apartments including EPH's (42%). An elderly client living in a house is likely to need assistance with household maintenance (internal and external), snow removal and grass cutting. Those regions with a high percentage of house dwellers will need to consider their client profile when planning service for their region.

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[9] Ibid.

As well, home safety factors become more important to elderly clients. There may be a need for:

- home or apartment renovations to allow wheelchair access, to bypass unmanageable stairs, or to move bathroom facilities to the main floor;
- supplies and equipment to reduce the risk of falling (e.g., bathtub/shower grab bars, bath mats, bath stools, non-skid hallway mats and stairway carpets, night lights, crutches, walkers, wheelchairs and so on); and,
- fire/disaster plans for apartment dwellers who cannot manage stairs.

The client's inability to meet these needs may mean the premature movement to safe, carefree facilities. The apartment dwellers of Winnipeg may raise the need for different types of client services.

Family Support

Seventy-five percent of clients have family living with them or within the same city. While the age of the adult relatives is unknown, it is possible that family can assume responsibility for all or part of the elderly client's care needs (e.g. house cleaning, home maintenance, financial management, transportation). Regions where clients lack close family proximity may need to be prepared to provide more support services than other regions.

Living Arrangement

Approximately one-half of the clients served by the Program live alone; the other one-half have one or more persons living with them. For the elderly clients living alone, there may be a need to:

- ensure client safety (e.g. daily friendly visitor);
- provide transportation to appointments; and,
- reduce social isolation (e.g. adult day care, community activities).

For the clients living with others, there is a need to consider the client's role and responsibilities in the household. Take, for example, a young mother with fractured ankles responsible for two children and a working husband. Support of the client in this situation may mean family support.

Statistics Canada reports the percent of population over 55 years of age, living alone, or with spouse as less likely to require help than persons living with others (Table 1). The predominant regional pattern of living arrangements must be considered when services are planned.

Health Status of Persons Living with Client

Thirty-five percent of clients living with other persons reported that the other member was unhealthy. There may be a need to consider the health and respite needs of the client caring for an unhealthy individual. Again, those regions with a high percentage of non-healthy individuals living with clients may be required to provide more respite services than other regions.

Table 1

PERCENT OF POPULATION OF 55 YEARS OF AGE AND OVER REQUIRING HELP OR UNABLE TO CARRY OUT SELECTED ACTIVITIES BY LIVING ARRANGEMENT, CANADA, 1985*

Activity	Live Alone	Live With Spouse	Live With Others
Yard work	39%	28%	51%
Heavy housework	16%	20%	38%
Grocery shopping	11%	11%	24%
Meal preparation	-	8%	14%
Managing money	4%	3%	11%
Light housework	-	3%	9%
Personal care	-	2%	6%

*Statistics Canada 1985

Employment Status of Person Living with Client

Clients reporting that household members worked outside of the home, stated that 77% worked days. This suggests that client care needs may be unattended during the day time when family/household members are not available. Social isolation reduction and safety needs should be met by providing services at times when the clients are alone or left unattended.

Future Client Profile

Based on the 1981 census data and the monthly maximum caseload, in June 1986, 0.1% of Manitoba's population 0 to 18 years of age was served by the Program. The proportion for the 19 to 64 age group was 0.5%. And, for individuals over 65 years of age and over; 8.5% of the provincial population was served by the Program.

In projecting the future client profile, one assumes the above proportions will remain constant. One also assumes that service delivery (type and frequency of services) will be relatively stable. If these assumptions are correct, the Program can expect significant growth by June 1996. The growth figure for the three age groups are as follows:

- -6% for clients 0 - 18 years of age;
- 15% for clients 19-64 years; and,
- 19% for clients 65 years of age and over.

By the year 2006, the Continuing Care Program will have experienced a 27% increase in clients 65 years of age and over and a 20% increase in clients between 19-64 years relative to the same time period in 1986. Data to support these findings is located in Appendix P.

Exhibit 10

SUMMARY FINDINGS : CLIENT PROFILE

VARIABLE	FINDINGS	SERVICE IMPLICATIONS
Age	. 79% clients over 65 years . 20% clients over 85 years	. needs of elderly population - future and present - transportation - personal care - shopping/banking - housework - personal care (heavy and light) - meal preparation - yard work
Sex	. 68% clients female	. needs of an elderly female population - house maintenance services (including yard work) - shopping/banking - health concerns
Marital Status	. 46% clients widowed	. needs of single elderly client population - counselling for grieving, loss and separation - social activities for singles
Language	. 84% clients speak English	. needs of English speaking clients - direct service worker language capabilities - written client material in English . needs of non-English speaking clients
Housing	. 55% clients reside in a house . 42% clients reside in an apartment (including EPH)	. needs of elderly living in a house - household maintenance - snow removal - yard work - renovations - prevention of falls . needs of elderly living in an apartment - renovations - prevention of falls - fire/disaster plan
Family Support	. 75% clients have family living with them or in the same city	. needs of elderly with family close by - needs may be met by family

Exhibit 10

SUMMARY FINDINGS : CLIENT PROFILE (Cont'd)

VARIABLE	FINDINGS	SERVICE IMPLICATIONS
Living Arrangement	. 51% clients live alone . 47% clients have one other person living in their home	. needs of elderly living alone - safety checks - transportation - reduced social isolation . needs of elderly not living alone - client role in family
Health Status of persons living with client	. 35% of client household members are not healthy	. needs of elderly client caring for unhealthy person - respite care - personal health
Employment Status of persons living with client	. 70% of client household members do not work outside home . 77% of client household members working outside the home work days	. needs of elderly left alone during the day - safety - reduced social isolation

8. CLIENTS' VIEW OF PROGRAM

BACKGROUND

The review was directed to address the appropriateness of current levels of client servicing and, in particular, to identify any areas of over servicing. In this chapter, the clients' views of the program are presented. Levels of client servicing are addressed from the clients' perspective. Regional variations are discussed in Appendix N, but will be highlighted throughout whenever appropriate.

DESCRIPTION

The clients' views of the program presented in this chapter are derived from the client survey data (n=1001). The survey asked questions regarding client:

- involvement in initial service decision;
- satisfaction with initial service implementation;
- knowledge of the appeal process;
- rating of valued services;
- satisfaction with service frequency;
- need for additional services;
- need for current services;
- satisfaction with current services;
- rating of home care services;
- response if home care was not available; and,
- response if home care service limits were to be established.

Exhibit 11 at the end of this chapter summarizes the findings and the implications resulting from the clients' view of the program. However, each area is addressed below. Appendix O contains the figures and tables displaying the findings discussed in this chapter.

FINDINGS

Client Involvement in Initial Service Decision

Clients were asked if they or their family were involved in the decisions regarding the type of services they would receive. Seventy percent of clients surveyed answered that they were not involved in the initial service decision regarding home care services. Of the 70% who were not involved, 56% of the clients had their services ordered by physicians and did not believe the service could be changed.

It is possible that clients will lack commitment to the established care plan if they are not part of the decision making process. Further, the lack of client involvement fosters the development of a dependent relationship between the Program and the client.

To increase client care plan commitment and to promote client independence, clients and family should be encouraged to participate actively in service decisions based on client care needs.

Client Satisfaction With Initial Service Implementation

Clients were asked if the services offered adequately met their care needs, if they were still receiving the services, if the services they received still met their care needs and finally, if the type of service they received was appropriate. The following information collected demonstrates client satisfaction with initial home care service implementation:

. 87% of clients believed services offered adequately met their care needs. Only 11% of clients believed more services were needed (e.g., more hours or more cleaning);

. 84% of clients are still receiving the services initially provided by home care and 88% believe they still meet their care needs; and,

. 91% of clients believe they received the correct type of home care service.

Clients also were asked if their preferences were considered when the services were ordered and generally, how would they rate their experience in initially obtaining services from the Program. Their answers to these two questions demonstrate further their satisfaction with initial home care service implementation:

. 69% of clients believed their preferences were considered when home services were ordered; and,

. 82% of clients rated their initial experience obtaining home care services as very positive or positive.

Clients believed that their preferences were considered, yet they also reported that they were not involved in the initial decision making process regarding Home Care services. These two statements are conflicting. If preferences were incorporated into the care plan, some client involvement was attained during the process. The validity of the response to client involvement is therefore questionable.

Client Knowledge Of Appeal Process

Clients were asked if they knew how to register a complaint or appeal the service decision of Program Staff. They also were asked how they would register a complaint and how they learned of the appeal process. Their responses were as follows:

- 57% of the clients were unaware of how to register a complaint or appeal a service decision;
- 66% of the clients who knew how to appeal a service decision would contact the case coordinator;
- 56% of the clients learned of the appeal process by program staff (social worker coordinator, direct service worker and other program staff); and,
- 70% of clients would contact program staff (including social workers and nurse coordinators) if they had a problem with their home care services and 14% did not know who to contact.

The above findings demonstrate the clients' lack of knowledge regarding the program's appeal process. Briefly, service problems will not be identified if clients do not report their concerns to the appropriate staff members. This concern is discussed further in chapter 11.

Client Rating of Valued Services

Clients reported the following when asked to identify the home care service they valued the most:

- 42% responded with homemaking services;
- 18% responded that all services were equal in value;
- 15% responded with nursing services; and,
- 13% responded with personal care services.

As for the 32% of clients who identified a second most valued service:

- 34% responded with nursing services;
- 22% responded with homemaking services;
- 12% responded with personal care services; and,
- 11% responded with equipment/supplies/dressing services.

Ninety-two percent of the clients responding to the question regarding valued services only identified two valued services. The remaining 8% providing a third valued service responded as follows:

- 19% identified nursing services;
- 19% identified equipment/supplies/dressing services;
- 15% identified all services as being equal; and,
- 15% identified day care/respite care services.

Client Satisfaction With Service Frequency

Client satisfaction with service frequency data highlights are as follows:

- more than 80% of clients are satisfied with the frequency of homemaking, personal care, nursing care, respite care, equipment, supplies and/or dressings and meals on wheels services;

- 15% of clients receiving therapy services were not satisfied with service frequency. Twenty-nine percent of the clients were over 85 years and 23% were short-term care clients; and

- 16% of clients receiving homemaking services were not satisfied with service frequency. Twenty-one percent were between 19 and 64 years of age and 19% were Winnipeg long-term care clients.

Generally speaking, home care clients are satisfied with the frequency of services provided. Of the clients who are not satisfied with service frequency, the majority live in Winnipeg.

Client Need for Additional Services

Clients were asked if they believed they needed additional home care services. A list of home care services was read aloud and the client responded positively or negatively to the need for the service read.

Approximately 90% of the clients surveyed did not believe they needed any additional home care services. Only 12% of clients not receiving homemaking services believed they needed this service. These findings suggest that the level of homemaking services is indeed quite rich.

Client Need for Current Services

Clients were asked to reflect on the services they currently received and to indicate which services they still required. More than 80% of the clients receiving homemaking, personal care, LPN nursing care, adult day care, respite care and meals on wheels believed these services were necessary. Generally, clients currently are receiving services they believe they need. Other findings included:

- 33% of clients receiving RN nursing services did not believe they were necessary. The figure for VON short-term care clients was 61%;

- 29% of clients receiving supplies/dressings did not believe they were necessary. The figure for VON short-term care clients was 48%; and,

. 33% of clients receiving therapy services did not believe they were necessary. The figure for Winnipeg long-term care clients was 42%.

There does appear to be a concern with short-term care VON clients with respect to RN nursing services and supplies and dressings. While clients may not be capable of judging their need for professional nursing services or supplies/dressings, they should be aware of the rationale for these services. Data above suggest that either a) short term care RN nursing services and supplies/dressings are not necessary or b) clients are unaware of the reason for these services. A further discussion of VON and short-term care in Winnipeg is contained in chapter 20.

Further, the Program staff are to be commended for their recognition and action regarding nursing over servicing across the province. Caseload review in 1987 focused on reviewing all cases receiving RN or LPN services. It is expected that the frequency of over servicing will be reduced as a result of this intensive investigation. The fact that staff are now sensitized to the issue also should help to reduce the incidence of an inappropriate level of servicing.

Between 1980 and 1986 approximately 38% to 46% of the program clients were discharged because they had improved or had sufficiently recovered to meet their own care needs. A further 12% to 19% during the same time period were discharged to the care of others (Tables 2 and 3). While these data suggest that over one-half of the program clients are discharged without institutionalization, there is no data on whether the discharges occur in a timely manner.

From the review of client files across the province, our consultants agreed that clients were generally kept on the program longer than what seemed necessary given the supporting documentation. It is quite

Table 2

REASONS FOR DISCHARGE FROM HOME CARE

DECEMBER 1980 - 1986

Reason/Year	1980	1981	1982	1983	1984	1985	1986
Facility admission	12%	12%	13%	14%	14%	15%	12%
Placement	9%	11%	7%	9%	6%	9%	6%
Deceased	20%	14%	15%	17%	17%	18%	17%
Service by others	16%	15%	19%	18%	14%	14%	12%
Patient improved/recovered	38%	43%	41%	38%	44%	38%	46%
Other	5%	5%	5%	5%	5%	6%	7%
	100%	100%	100%	100%	100%	100%	100%
	n=699	n=842	n=833	n=853	n=728	n=840	n=1,055

Table 3

NUMBER OF ADMISSIONS/DISCHARGES IN HOME CARE

DECEMBER 1980 - 1986

Admissions/ Discharges/ Year	1980	1981	1982	1983	1984	1985	1986
Total admissions	705	792	790	765	785	963	941
Total discharges	699	842	833	853	728	840	1,055

possible that the client files lacked the documentation necessary to justify continued program involvement; however, the potential over servicing identified in the client survey data tend to corroborate the consultant's field work findings. Over servicing could be related to either or both length and frequency of service provision.

Client Satisfaction with Current Services

Clients also were asked to reflect on the services they currently received and to indicate which areas could be improved. More than 75% of clients receiving personal care, nursing care, adult day care, respite care, equipment, and supplies and dressings did not believe these services needed improvement. Generally, clients are satisfied with their current home care services.

However, 21% of clients receiving homemaking services believed these services could be improved. For Winnipeg long-term care clients and for VON short-term care clients these figures were 25% and 21% respectively.

Responses such as the following were provided when asked how home making could be improved:

- more capable workers (34%);
- more hours (32%);
- heavy cleaning (9%);
- more services (8%); and,
- less stipulations on the type of services that can be provided (8%).

Client Rating of Home Care Services

Ninety percent of the clients surveyed rated the Home Care services as good or excellent. Further, 92% home care clients had no concerns regarding the services they received.

Client Response if Home Care was not Available at Time of First Contact with Program

Clients were asked to think back to the time when they first contacted the Continuing Care Program. They were then asked what they would have done if the Continuing Care Program were not available. The responses were as follows:

- 48% of clients would have remained at home. Of these clients, 45% would have used help from family and/or friends, 25% would have hired outside help and 19% would not have used any help; and,

- 37% of clients would have moved elsewhere. Of these clients, 44% would have moved into a Personal Care Home and 17% would have moved into an Elderly Person's Housing Unit.

The above data suggest that family and/or friends are available to assist with client care. They also suggest that clients are willing to pay for home care services.

Since 44% of the clients who would have moved (n = 365) indicated that they would have entered a Personal Care Home, the data suggest that the existence of Home Care prevented the premature institutionalization of 163 clients in the survey (or 16% of the total client population).

Client Response if Home Care Service Limits were Established

Clients were asked what they would do today if service limits were established for Home Care. Their responses are as follows:

. 32% of clients do not know what they would do;

. 21% of clients would ask family/friends for assistance;

. 19% of clients would manage with less services;

. 15% of clients would move elsewhere. Of these clients, 65% would move into an Elderly Persons Housing Unit and 13% would move into a Personal Care Home; and,

. 13% of clients would pay to have someone deliver the services.

The above data suggest that approximately one third of the clients are unprepared for service limits within Home Care. However, over 50% of clients surveyed are capable of meeting their care needs through their own resources (family, less service, purchased services).

In summary, there is generally a high degree of client satisfaction with:

. attaining Continuing Care services;
. service type and frequency;
. service delivery; and,
. quality of services provided.

Clearly, clients believe that they are receiving a quality service from the Continuing Care Program.

There were, however, data from the client survey that give rise to concern regarding client involvement in the Program. First, there may be a potential lack of client commitment to care plans and/or service decisions when 70% reported that they were not involved in the initial service decisions. Although there are data to suggest they were involved in the process (68% clients reported that their preferences were considered), this potential lack of involvement may promote client dependency rather than client independence. Consideration should be given to implementing strategies to involve the client more at the program entry level. One such strategy would be to have the client agree to and sign their service plan, establishing a contract between the Program and the client. This would ensure involvement and promote client independence. This strategy has been implemented within the Integrated Homemaker Program in Ontario with good success.

Second, the large percentage of clients (57%) unaware of the appeal process is of concern and will be discussed further in chapter 15. At this point, however, it is important to emphasize the need for, and adherence to, a client appeal process for the frail and vulnerable clients in the Program. If the contract concept is adopted, the appeal process could be incorporated as a component of the service plan. The client signature would indicate their understanding of and commitment to use the appeal process.

As for the impact of the Program on clients, there are mixed findings. Approximately one-half of the client population surveyed reported their ability to manage their care needs through their own resources (i.e., use of family/friends, managing without the service, or purchasing the service). The other one-half of the client population would have either moved from their home into an Elderly Persons' Housing Unit or a Personal Care Home, or they were not sure how they would have managed.

On the one hand, the data suggest that clients are over serviced given their self reported ability to manage without the Program. On the other hand, the data also suggest that the Program prevented the premature movement of clients from their homes and assisted clients to remain within their communities. Service implications based on these findings can be as diverse as the findings themselves. However, one cannot ignore the data that strongly suggest many clients are capable of managing their own care needs.

The program might consider investigating further those regions that are more capable of accessing resources outside the Program (e.g., family, not-for-profit services in Winnipeg), and/or those non-professional services that can be provided on a not-for-profit basis (e.g., homemaking). A further analysis of clients receiving "homemaking only" services is provided in Appendix Q.

Exhibit 11

SUMMARY FINDINGS: CLIENT VIEW OF THE PROGRAM

VARIABLE	FINDINGS	SERVICE IMPLICATIONS
Client Involvement in Initial Service Decision	. 70% of clients were not involved in the initial service decision. . 14% of clients had services ordered by a Physician.	.potential lack of client commitment to care plan. .promotion of client dependence
Initial Service Implementation Satisfaction	. 87% of clients believed services offered adequately met care needs. . 84% of clients are still receiving initial services provided and 87% believe they still meet their care needs. . 91% of clients believe they received the correct service type. . 69% of clients believed their preferences were considered when the services were ordered. . 82% rated initial experience of obtaining services as very positive or positive.	.maintain postive program image with initial service implementation
Knowledge of Appeal Process	. 57% of clients are unaware of appeal process . 66% of clients knowing how to appeal service decision would contact the case coordinator . 56% of clients learned of the appeal process by program staff . 70% of clients would contact program staff if they had a problem with their services - 14% did not know who to contact - 9% would contact family /friends	.client service problems may not be identified . program staff will be notified if client experiences service problems.

Exhibit 11

SUMMARY FINDINGS: CLIENT VIEW OF THE PROGRAM (Cont'd)

VARIABLE	FINDINGS	SERVICE IMPLICATIONS
Rating of Valued Service	. 42% of clients valued their homemaking services the most. . 18% of clients valued all services equally . second most valued service was nursing.	. ensure clients receive the valued homemaking and nursing services.
Satisfaction with Service Frequency	. 15% of clients receiving therapy services were not satisfied with the frequency of services - 23% were short-term care clients - 29% of clients were over 85 years . 16% of clients receiving homemaking services were not satisfied with the frequency - 19% were from Winnipeg - 21% were between 19 and 64 years of age	. continue current service frequency. . review frequency of Winnipeg therapy and homemaking services.
Need for Additional Home Care Services	. 12% of clients not receiving homemaking services believed they needed homemaking. . >85% of clients did not believe they needed additional services.	. continue to ensure services are available.
Need for Current Home Care Services	. >80% of clients receiving - homemaking - personal care - LPN nursing care - adult day care - respite care - meals on wheels believe these services are needed. . 33% of clients receiving RN nursing services did not believe they were necessary. -61% were VON short-term care clients -29% of clients receiving supplies/equipment did not believe they were needed. -48% were VON short-term care clients	. VON may be over servicing with respect to nursing services and supplies/dressings.

Exhibit 11

SUMMARY FINDINGS: CLIENT VIEW OF THE PROGRAM (Cont'd)

VARIABLE	FINDINGS	SERVICE IMPLICATIONS
	. 33% of clients receiving therapy services did not believe they were needed. . 42% were from Winnipeg	
Satisfaction with Current Services	. 75% of clients receiving - personal care - nursing care - adult day care - respite care - equipment - supplies and dressings did not feel these services needed improvement. . 21% of clients receiving homemaking services believed the services needed improvement.	. homemaking services in Winnipeg could be improved (short-term and long-term).
Rating of Services Provided	. 90% of clients rated services as good or excellent. . 92% of clients had no concerns regarding the services they received.	. continue quality of home care services.
Client Response if Home care were not available	. 48% would have remained at home - 45% would have used help from family/friends - 25% would have hired help. . 19% stated no assistance would have been necessary . 37% would have moved elsewhere - 44% into a EPH - 17% into PCH	. family/friends may be accessible for care assistance . clients capable of meeting care needs through own resources . home care prevented premature institutionalization

Exhibit 11

SUMMARY FINDINGS: CLIENT VIEW OF THE PROGRAM (Cont'd)

VARIABLE	FINDINGS	SERVICE IMPLICATIONS
Client Response if Home care service limits established	. 32% do not know what they would do . 15% would move elsewhere - 65% into EPH - 13% into PCH . 19% would manage with less service . 21% would have family /friends assist. . 13% would pay to have someone deliver the service.	. one third of client population unprepared for service limits. . one half of client population capable of meeting care needs through own resources.

PART IV : REVIEW OF MANAGEMENT

INTRODUCTION

This part of the report reviews the following aspects of the Program:

- Information Systems (issue number 5 in chapter 2);
- Budgetary Control (issue number 4 in chapter 2);
- Forecasting Demand and Program Planning (issue number 3 in chapter 2);
- Management Accountability (issue number 6 in chapter 2); and
- Staff Training (issue number 15 in chapter 2).

Each chapter is summarized in exhibits located at the end of the chapter.

9. INFORMATION SYSTEMS

BACKGROUND

The responsibility for information systems development for the Continuing Care Program rests with the Health Information Systems Division of the Manitoba Health Services Commission (MHSC). This responsibility assignment is a product of efforts directed towards integrating Departmental and MHSC data processing under one focus of responsibility. An over-riding objective of these efforts is the establishment of an integrated management information system supporting all aspects of health care in Manitoba.

A Computer Steering Committee has been established with senior representatives of both Manitoba Health and MHSC. Its terms of reference are to:

- approve long- and short-range computer plans and oversee implementation of these plans;
- set, approve and/or ensure implementation of policies relating to the use of information (information management) and computer resources;
- determine project priorities; and,
- review the progress of approved projects.

The Division is responsible for the production of the Annual Information Technology Systems Plans for Manitoba Health and MHSC. This Plan is submitted to the Department of Finance as part of the annual budget process.

The 1988/89 Plans (see Exhibit 12, following) emphasize continued work in converting community health applications to the mainframe. Priority also is being given to expanding and improving access to the Province's communications network.

The Plans identify a small number of projects relating to the needs of the Continuing Care Program. Specifically:

- the redevelopment of the Home Care payroll system;
- Community Health Data Base - its development and implementation of an integrated data base for the Community Health Service Division; and,
- Community Care - the research, design and development of a management information system for the Office of Continuing Care.

Other projects planned for the Department include the following:

- installation of communications equipment throughout Manitoba Health regional and central offices and the establishment of communication links to Manitoba Data Services; and,
- the redesign and rewrite of the client registry and inventory control application at the Medical Supplies and Home Care Equipment Branch.

FINDINGS

The amalgamation of data processing under MHSC has occurred relatively recently. While considerable efforts are being expended to meet the demands and needs of both Manitoba Health and MHSC, the fact of the matter is that the Information Services Division has very few resources

Exhibit 12

MANITOBA HEALTH SERVICES COMMISSION
1988/89 ANNUAL SYSTEMS PLANS RECONCILIATION
(000'S)

		Current Year 1987/88	1988/89	1989/90	1990/91
I. Institutional, Medical and Other Health Programs (M.H.S.C.)					
. Personnel Costs - 77.0 SY's		$ 1,977.3	$ 1,953.4	$ 1,953.4	$ 1,953.4 [1]
. Computer, hardware rental and maintenance, software, education, personal computers, etc.		2,051.0	2,373.3	2,585.3	2,825.5
. Word processing/AES, consumables		86.0	25.0	25.0	25.0
Total - per Lotus Summary		$ 4,114.3 [2]	$ 4,351.7	$ 4,563.7	$ 4,803.9
II Regional and Community Based Programs (Department)					
. Personnel - 10.0 SY's		$ 394.9	$ 382.9	$ 382.9	$ 382.9 [1]
. Computer, hardware, maintenance, software, communications, education, etc.	726.6				
Less: reductions by Cabinet	(130.0)	596.6	600.0	600.0	600.0
Total - per Lotus Summary		991.5	982.9	982.9	982.9
Total - per 2 Summaries		$ 5,105.8	$ 5,334.6	$ 5,546.6	$ 5,786.8
Total - per M.H.S.C. Administration Budgets					
. M.H.S.C.		4,913.8	5,122.6	5,314.6	5,539.8
. Cadham		192.0	212.0	232.0	247.0
		$ 5,105.8	$ 5,334.6	$ 5,546.6	$ 5,786.8
III Consolidation					
. Personnel - 87.0 SY's		$ 2,372.2	$ 2,336.3	$ 2,336.3	$ 2,336.3 [1]
. Computer, hardware, maintenance, software, communications, education, word processing, etc.		2,733.6	2,998.3	3,210.3	3,450.5
		$ 5,105.8	$ 5,334.6	$ 5,546.6	$ 5,786.8

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[1] No provision is included for possible salary increases in accordance with Treasury Board directives regarding completion of the Estimates.

[2] Includes an amount of $34.0 for microfilm/microfiche not included in spreadsheets ($4,114.3 - 34.0 = 4,080.3)

at its disposal for proper strategic management information planning, development and delivery. In fact, over $300,000 was reduced from the 1987/88 Division budget - a removal that was largely at the expense of planning and development activities. The forecasted budget requests through to 1990/91 fall considerably below inflation. It is within the context of the relative lack of resources assigned to meet the management information needs of the Home Care Program that the following findings are made:

- Inadequate resources have been assigned to meet the government's information needs for this program. A program which will exceed $41 million in 1988/89 and which has grown at an annual rate far in excess of inflation has virtually no management information available to it and only a small 18 month planning commitment for the future. This state of affairs can be contrasted with both Saskatchewan and Alberta, which have established effective and powerful home care management information systems, and continue to expend resources to integrate these systems with their planning, budgeting, funding and accountability systems. At the current and forecasted levels of budget allocation to the Division, no meaningful information, planning and systems delivery will take place during the next three to three and one-half years.

- There is no strategic data plan for Manitoba Health and MHSC which will allow it to meet its information systems integration mandate. Most of the Division's efforts are consumed by day-to-day operations, maintenance and supporting the government's communications strategy. There appears to be no senior governmental commitment to making management information in this area a priority. The Kanes' report pointed out that the Continuing Care Program was established as a separate entity from the Commission because the Program's services transcended health care and need to be well linked to other services at the local level. There is no evidence that the other information needs (i.e., integrated information on personal care homes, hospitals and the broad range of Continuing Care Program services) are being addressed. A strategic data plan would address specifically how each of these program areas would be linked one to the other and how they would be used as an integrated system.

- Current home care information systems are largely manual or, where automated, support administrative functions. Issues of data requirements, data reliability, etc. are not addressed fully, or indeed, at all. There is a great deal of uncertainty about whose responsibility these issues are.

- The Home Care Payroll system re-write is attempting to address the need for capture of client information. However, these client data are being captured without reference to an overall data strategy. As well, there apparently are no plans to include VON in any of the home care management information systems development.

- The work underway on the Community Health Information System has great potential. The work plan of the working group calls for the completion of a preliminary systems definition by the end of February. However, it is not clear that Continuing Care has been involved to any great extent or that its management information needs will be met by this system. The proposed system is intended to develop a strategic plan for the development of Community Health data bases. As well, it is intended to provide Community Health with the flexibility to priorize those program areas most in need of computer resources at the present time. No additional information on this plan is available until the Working Group completes its first phase. However, the plan may encounter user problems since

Program Management staff were not represented on the working group.

As well, there is no indication that the Ministry regards this system as a high priority.

- The management information needs of those outside the Department and MHSC are not being addressed. Both Treasury and partners in the delivery of home care have important information needs. There is little evidence that the total home care program information needs have been or are being considered. This omission seriously compromises the credibility of the Program with Treasury.

- No apparent consideration has been given to fast payback projects that might meet some of the information needs for home care (i.e., use of VM/AS type tools for the existing data base, the use of other provincial systems such as Alberta's or Saskatchewan's on an interim basis, manual sampling of cases, etc.). In practical terms, given current plans and resources, the Manitoba Home Care Program will not have a useful management information system for several years. Since there is, as yet, no clear definition of what such a system might entail, there is no long-term financial commitment to, and little senior management support for, building such a system.

- There is little evidence of formal qualitative and/or quantitative analysis of the home care program data distribution needs. The Division's efforts to gain some sense of control over the proliferation of various computer equipment need to be reinforced and formalized as part of a top management supported strategic data planning effort.

- The Division's establishment of an information centre is laudable. Much more short-term pay off for Home Care and for other Departments and MHSC needs could be achieved by assigning a data specialist (as opposed to a data processing expert) to the centre (similar to Ontario, Alberta and many other government departments across Canada). Such an expert could concentrate on producing ad hoc and regular reports for management using a wide variety of information sources.

- Little evidence was found of plans to address the government's immediate needs for integrated long-term care information needs. Without integration, comprehensive information or short- and long-term community and in/stitutional based care, the Government's ability to plan and manage its health care system for those requiring continuing care will be compromised seriously. The placement of the responsibility to do this planning in the MHSC needs to be reassessed since the nature of the business of MHSC is oriented towards payments and accounting systems and not toward the design, development and delivery of broad-based management information systems. Without a substantial commitment of attention and resources of Manitoba Health to this area, the MHSC cannot be expected to meet the management information needs of the Department or, more specifically, of the Continuing Care Program.

OPTIONS

Any options open to the Department and to MHSC will require the commitment of additional management information systems resources. In the short-run and with limited resources, options which might be pursued are:

- the enhancing of the Division's information centre to include a data specialist dedicated to continuing care management information similar to Alberta Social Services. For a very small investment this specialist would be able to produce effective interim management information reports for the Department.

- the purchase of the Alberta Coordinated Home Care Program Information System as an interim solution to the long-term information needs of the CCP. This system, we are advised, could be made available to Manitoba at no charge. However, Manitoba would be responsible for any conversion costs to Manitoba Data Services systems. The Alberta System is directed towards meeting the information needs of managers at all levels:

  - Local Health Authority Boards;
  - Directors of Local Health Authorities;
  - Local Program Coordinators;
  - Local Case Coordinators; and,
  - the Home Care Directorate.

- the system provides reports dealing with client description, referral patterns, resource utilization, and program effect. A complete listing of the reports generated by this system is contained in Exhibit 13, following. In reality, with this system the long-term information needs of the program would need to be met only through the integration of a system of this sort with a long-term care system including hospitals and personal care homes.

- the acceleration and reassessment the Home Care payroll project, the Continuing Care project and the community health systems projects. This reassessment should address strategic data planning requirements and how the payroll system might be integrated with a system such as that from Alberta.

Exhibit 13

ALBERTA'S COORDINATED HOME CARE INFORMATION SYSTEM
SUMMARY OF MANAGEMENT REPORTS

SUBJECT AREA	REPORT NUMBER	REPORT TITLE
CLIENT DESCRIPTION	CD 1	Age/Sex Distribution
	CD 2	Diagnostic Groups for Current Clients
	CD 3	Initial Client Status Distribution Trends
	CD 4	Caseload Statistics
REFERRAL PATTERNS	RP 1	Referral Locations Summary - For Discharged Clients
	RP 2	Referral Locations Summary - For Non-Admissions
	RP 3	Referral Sources - For Admitted Clients
	RP 4	Referral Sources - For Non-Admissions
	RP 5	Reasons for Non-Admission
	RP 6	Reasons for Discharge
	RP 7	Location Detail - Referral From
	RP 8	Location Detail - Referral To
	RP 9	Re-Admission Trends
RESOURCE UTILIZATION	RU 1	Length of Stay and Cost of Service - Current Clients
	RU 2	Length of Stay and Cost of Service - Discharged Clients
	RU 3	Costs by Combination of Service - Current Clients
	RU 4	Costs by Combination of Service - Discharged Clients
	RU 5	Service Consumption Trends - Units
	RU 6	Service Consumption Trends - Hours
	RU 7	Activity Summary
	RU 8	Activity Detail
	RU 9	Resource Utilization Trends
	RU 10	Service Provision Summary
	RU 11	Travel Time Summary
PROGRAM EFFECT	PE 1	Client Improvement Trends
	PE 2	Client Outcome Trends - Initial Prediction
	PE 3	Client Outcome Trends - Updated Pred[illegible]n

Exhibit 13.01

Coordinated Home Care Program

ADMISSION DATA

CLIENT I.D.: ____-______ AHCIP: ___ __ ___ ___

NAME: Surname ______ First Name ______

ADDRESS: Street ______

Town/City ______ Postal Code ______

Phone Number ______ (403)

BIRTHDATE: Year __ Month __ Day __

SEX: F / M CASE COORDINATOR: ____-___

MARITAL STATUS: S / M / D / X / W / C

S-Single; M-Married; D-Divorced; X-Separated; W-Widowed; C-Common Law

PHYSICIAN: ______

EMERGENCY CONTACT: Name ______

Address ______

Town ______ Postal Code ______

Phone (Home) ______ (Work) ______

Relationship ______

THIRD PARTY: Y / N (Y-Yes; N-No) Ins. I.D. __ ______

Max. ___.__

BILLING ADDRESS: 1 / 2 / 3

1 - Client's address; 2 - 3rd Party (specify); 3 - Bill to address

BILL TO ADDRESS: Name ______

Address ______

Town/City ______ Postal Code ______

ADMISSION DATE: Year __ Month __ Day __

INITIAL LEVEL OF CARE: 1 / 2 / 3 / 4 REASSESSMENT: __ __ __

1 - Acute; 2 - Rehab; 3 - Chronic; 4 - Palliative

Option D 001 (frail elderly)

PROGRAM/AGENCY REFERRED TO: ______ : (Code: ___)

PRIMARY DIAGNOSIS: ______ : (Code: ___)

SECONDARY DIAGNOSIS: ______ : (Code: ___)

ADDITIONAL DIAGNOSIS: 1 (Yes) / 2 (No)

ADDITIONAL CLIENT DESCRIPTION:

LIVING ARRANGEMENT: 1 / 2 / 3 / 4

1 - alone; 2 - with spouse only; 3 - with spouse & others; 4 - with others

INITIAL CLIENT STATUS __ INITIAL PREDICTED CLIENT OUTCOME __

LOCATION UPON REFERRAL:

	Name	Code
1. General Hospital	______	_ _ _
2. Auxiliary Hospital	______	_ _ _
3. Psychiatric Hospital	______	_ _ _
4. Nursing Home	______	_ _ _
5. Lodge	______	_ _ _
6. Other Residential Facility		4 6 6
7. Private Dwelling		4 7 7

SOURCE OF REFERRAL: 1 / 2 / 3 / 4 / 5 / 6 / 7

1 - Staff of Facility; 2 - Self/Family/Friend; 3 - Physici[illegible]

4 - LHA Staff; 5 - Other CHCP; 6 - Other Agency; 7 - Other[illegible]wn

Exhibit 13.02

Coordinated Home Care Program

NON-ADMISSIONS

Client I.D.: ____ - ______ AHCIP: ___ __ ___ ___

Rejection Date: __ __ __
Year Month Day

Name: Surname ______________ First Name ______________

Address: Street ______________
Town/City ______________ Postal Code ______________
Phone Number ______________ (403)

Birthdate: __ __ __
Year Month Day

Sex: F / M Case Coordinator: ____ - ___

Marital Status: S / M / D / X / W / C
S-Single; M-Married; D-Divorced; X-Separated; W-Widowed; C-Common Law

Physician: ______________

Part 3

Option A: ___ B: ___

Location Upon Referral:

	Name	Code
1. General Hospital	______________	___
2. Auxiliary Hospital	______________	___
3. Psychiatric Hospital	______________	___
4. Nursing Home	______________	___
5. Lodge	______________	___
6. Other Residential Facility	______________	4 6 6
7. Private Dwelling		4 7 7

Source of Referral: 1 / 2 / 3 / 4 / 5 / 6 / 7
1-Staff of Facility; 2-Self/Family/Friend; 3-Physician;
4-LHA Staff; 5-Other CHCP; 6-Other Agency; 7-Other/Unknown

Part 4

Option A: ___ B: ___ C: ___

Reasons for Non-Admission:

1. ____
2. ____
3. ____
4. ____

A. Individual/Family Car Manage Care
B. No Medical Service Required
C. Individual/Family Refused Service
D. Requires Level of Care Beyond Home Care Mandate
E. Lives Outside Program Service Area
F. Requires Type of Service Not Provided
G. Home Care Has Insufficient Resources
H. Physical Environment Not Suitable
I. No AHCIP Number
J. Not Approved or Authorized by Physician
K. Other

Part 5

Option A: ___ B: ___

Location Referred to:

	Name	Code
1. General Hospital	______________	___
2. Auxiliary Hospital	______________	___
3. Psychiatric Hospital	______________	___
4. Nursing Home	______________	___
5. Lodge	______________	___
6. Other Residential Facility	______________	4 6 6
7. Private Dwelling		4 7 7
8. N/A (for deceased only)		4 8 8

Program/Agency Referred to: ______________ [illegible]de: ___)

DS015Q 0027.0.0

Exhibit 13.03

Coordinated Home Care Program

CLIENT DISCHARGE

Name: ____
Surname First Name

Client I.D.: _ _ - _ _ _ _ _ _

Location Referred to:

	Name	Code
1. General Hospital	____________________	_ _ _
2. Auxiliary Hospital	____________________	_ _ _
3. Psychiatric Hospital	____________________	_ _ _
4. Nursing Home	____________________	_ _ _
5. Lodge	____________________	_ _ _
6. Other Residential Facility		_ _ _
7. Private Dwelling		_ _ _
8. N/A (for deceased only)		_ _ _

NOTE: Location upon referral for Types 6/7/8, enter a blank for the code.

Discharge Date: _ _ _ _ _ _ _ _
Year Month Day

Discharge Reason: 1. ________
2. ________
3. ________

A. No Longer Requires Any Service
B. Individual/Family Can Manage Care
C. Medical Service No Longer Required
D. Individual/Family Refused Service
E. Admitted To Health Care Facility
F. Moved
G. Deceased
H. Requires Type of Service Not Provided
I. Home Care Has Insufficient Resources
J. Not Approved Or Authorized By Physician
K. Other

DS014U 0026.0.0

Exhibit 13.04

Home Care I.D. ______________________________

Service Authorizations for the Client

Type	Provider Code	Act ivity	Eff. Date	Termination Date	Period	Freq Unit	Freq Hrs.
___	___________	--	_/_/_	_/_/_	--	--	--
___	___________	--	_/_/_	_/_/_	--	--	--
___	___________	--	_/_/_	_/_/_	--	--	--
___	___________	--	_/_/_	_/_/_	--	--	--
___	___________	--	_/_/_	_/_/_	--	--	--
___	___________	--	_/_/_	_/_/_	--	--	--
___	___________	--	_/_/_	_/_/_	--	--	--
___	___________	--	_/_/_	_/_/_	--	--	--
___	___________	--	_/_/_	_/_/_	--	--	--
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___	___________	--	_/_/_	_/_/_	--	--	--
___	___________	--	_/_/_	_/_/_	--	--	--
___	___________	--	_/_/_	_/_/_	--	--	--
___	___________	--	_/_/_	_/_/_	--	--	--
___	___________	--	_/_/_	_/_/_	--	--	--
___	___________	--	_/_/_	_/_/_	--	--	--
___	___________	--	_/_/_	_/_/_	--	--	--
___	___________	--	_/_/_	_/_/_	--	--	--

Types: S = Start, T = Terminate, C = Change or Continue

Period: D = Daily, W = Weekly, B = Bi-weekly, M = Monthly

1 = Monday, 2 = Tuesday, 3 = Wednesday, 4 = Thursday, 5 = Friday,
6 = Saturday, 7 = Sunday

Followup Reminders
Coordinator ----‐--- (Leave Blank for Client Reminders)

HCID	DATE	CODE	MESSAGE
----‐---	--/--/--	___	______________________________
----‐---	--/--/--	___	______________________________
----‐---	--/--/--	___	______________________________
----‐---	--/--/--	___	______________________________
----‐---	--/--/--	___	______________________________

R = Reassessment, O = MD Orders Due, P = Progress Report to MD.

Exhibit 13.05

HOME CARE INFORMATION SYSTEM

REPORT ID: WR422

.H.A. : 28 STURGEON HEALTH UNIT
UB-OFFICE : 02 WESTLOCK, ALBERTA

SERVICE RECORDS TURNAROUND DOCUMENT
FOR THE WEEK ENDING: 87-09-13

PAGE: 7

ENDOR OR EMPLOYER: 26 WESTLOCK F.C.S.S.

PROVIDER: H26000 WESTLOCK HOMEMAKER SERV. RELIEF: __________

.C.I.D. 2802-	--AUTHORIZED SERVICES-- ACTIVITY FRQ FRQ PER CODE UNITS HRS	C/UNIT C/HOUR TOTAL COST	MON 09-07	TUE 09-08	WED 09-09	THU 09-10	FRI 09-11	SAT 09-12	SUN 09-13
000453 [redacted] Sarah	87-07-01 - 87-12-31 30 1 2.50 B	9.25	.	.	.	.	.	.	.
000052 [redacted] THELMA	87-08-16 - 87-12-16 25 1 0.50 W	9.25	.	P 50	.	.	.	.	.
00621 [redacted] Doris	87-07-17 - 87-12-31 30 1 2.00 W	9.25	.	.	.	.	H 2.00	.	.
00494 [redacted] Rebecca	87-06-12 - 87-12-12 25 1 0.50 W	9.25	.	P 50	.	.	.	.	.
00290 [redacted] Barbara	87-04-01 - 87-09-30 25 1 0.75 W	9.25	.	.	.	P 75	.	.	.
	87-04-01 - 87-09-30 30 1 3.00 W	9.25	.	H 3.00	.	.	.	.	.
00709 [redacted] MIKE	87-07-01 - 87-12-01 25 1 0.50 W	9.25	.	.	.	.	P 50	.	.
00009 [redacted] Ethel	87-09-01 - 88-02-29 25 1 0.50 W	9.25	.	.	.	.	P 50	.	.
J149 [redacted] Macy	87-07-20 - 87-11-30 30 1 2.00 W	9.25	.	.	.	H 2.00	.	.	.
0805 [redacted] AGNES	87-08-12 - 87-11-30 25 1 0.50 W	9.25	.	P 50	.	.	.	.	.
	87-08-17 - 87-11-30 30 1 3.00 W	9.25	.	H 2.00	.	.	.	.	.
0518 [redacted] Dorothy	87-06-17 - 87-12-17 25 1 0.75 W	9.25	.	P 75	.	.	.	.	.
0608 [redacted] Corinne	87-07-01 - 87-12-01 25 1 0.75 W	9.25	.	.	.	P 75	.	.	.

ING KEY:
25 - P PERSONAL CARE 30 - H HOMEMAKING 34 - S ADULT SITTING

In summary, the Alberta information system provides a practical, workable approach given the constraints of existing MHSC data processing resources and the costs and lapsed time associated with developing a totally new system. The Alberta information system entails completing as well as coding specific client services sheets. (See Exhibit 13.) At the admission stage, services to be delivered would be captured on one of these sheets as well as the service cost, and the sheet would be authorized and coded. Once services are delivered, the coded client services sheets become the payment mechanism for direct service workers and V.O.N. Therefore, these client service sheets are the input documents for a financial, statistical and evaluation data base. Converting, implementing, and coordinating the Alberta information system would be an integral part of the data specialist's job function.

Along with the work currently underway on the payroll system, the Alberta system would allow the OCC to administer and manage the program more effectively. It is important to note that these (and the many adhoc reports which the system is capable of producing as described in Exhibit 13) would provide the program with virtually all the management information tools which it would require, at next to no cost to the Department.

In the long-run, it is hard not to observe that priority needs to be given and sufficient resources assigned to developing a strategic data plan for Manitoba's long-term health care program overall. These programs will continue to grow and continue to come under substantial resource pressure. Manitoba's ability to manage its long-term health care system is seriously compromised now by its inability to access timely, accurate and useful information.

Exhibit 14 at the end of the chapter presents the summary findings for Information Systems.

Exhibit 14

SUMMARY FINDINGS: INFORMATION SYSTEMS

ISSUES/CONCERNS	IMPLICATIONS	OPTIONS
. inadequate resources assigned to MIS . current system largely manual . no strategic data plan exists . Payroll System - no plans to include VON and other components of delivery in client data models . Payroll System - no system identification . information centre capability could be enhanced to support a number of immediate and pressing needs . PC based interim solutions might be "imported"	. minimal management information will be available in the foreseeable future . Planning and management information needs not addressed . inefficiencies . loss of opportunities . incomplete data . opportunity loss . loss of true user perspective . opportunity for significant short-term payback . some minor cost outlay may be required	. The enhancing of the Division's information centre to include a data specialist dedicated to Continuing Care management information similar to Alberta Social Services. . The purchase of the Alberta Coordinated Home Care Information System. Minor modifications and low cost might offer a quick interim solution which may well serve as an integral part of the program's long-term solution. . The acceleration and reassessment of the Home Care payroll re-write project, the Continuing Care project and the community health system project. Reassessment should address strategic data planning requirements.

INFORMATION SYSTEMS: RECOMMENDATIONS

1. THE INFORMATION SERVICES DIVISION 1988/89 DEVELOPMENT BUDGET FOR THE HOME CARE PAYROLL SYSTEM RE-WRITE, COMMUNITY SERVICES AND CONTINUING CARE PROJECTS SHOULD BE APPROVED. NO FURTHER BUDGETARY EROSION IN THIS DIVISION SHOULD BE PERMITTED.

2. THE DEPARTMENT SHOULD GIVE PRIORITY TO THE COMPLETION OF A LONG-TERM CARE STRATEGIC DATA PLAN. THIS PLAN SHOULD BE COMPLETED AS SOON AS POSSIBLE.

3. THE INFORMATION SERVICES DIVISION SHOULD GIVE IMMEDIATE PRIORITY TO DEVELOPING A DATA STRATEGY THAT WILL ADDRESS THE INTEGRATED HOME CARE PAYROLL, CONTINUING CARE AND COMMUNITY SERVICE PROJECT.

4. THE INFORMATION SERVICE'S DIVISION SHOULD ENHANCE ITS INFORMATION CENTRE WITH A DEDICATED DATA SPECIALIST WHO WILL CONCENTRATE ON THE SHORT-TERM INFORMATION NEEDS OF CONTINUING CARE. IN THE LONGER-TERM, THE DIVISION SHOULD EXAMINE THE APPROACHES USED IN OTHER GOVERNMENT HEALTH AND HUMAN SERVICE ENVIRONMENTS FOR THE STAFFING AND OPERATION OF INFORMATION CENTRES WITH THE VIEW TO CREATING A MODEL APPROPRIATE TO MANITOBA.

5. THE ALBERTA COORDINATED HOME CARE INFORMATION SYSTEM SHOULD BE OBTAINED AS AN INTERIM SOLUTION. CLOSE COLLABORATION WITH BOTH ALBERTA AND SASKATCHEWAN IN FUTURE HOME CARE SYSTEMS DEVELOPMENT SHOULD BE PURSUED. OPPORTUNITIES FOR SHORTENED DEVELOPMENT TIMES AND REDUCED COSTS EXIST IN SUCH COLLABORATION. IT MAKES LITTLE SENSE FOR THREE WESTERN PROVINCES TO DUPLICATE EFFORTS AND COSTS IN THIS AREA WHEN THERE IS AN EXPRESSED WILLINGNESS TO SHARE AND COLLABORATE.

10. BUDGETARY CONTROL

BACKGROUND

The Continuing Care Program falls mainly under two distinct government expenditure votes and correspondingly is covered by two separate budget structures. Services purchased from direct service workers and contracted agencies are covered by the Home Care Assistance budget. Operating expenditures associated with regional staff managing and coordinating the Program at the regional level are subsumed in the Community Health staff operating budgets. There are, in fact, some additional costs associated with the Continuing Care Program that are met from a third source, the Manitoba Health Services Commission (MHSC), which is responsible for day care and respite care. These represent a small proportion of program related expenditures.

Home Care Assistance

The Home Care Assistance budget is managed at the corporate level by both the Administrative Services Division and the Office of Continuing Care. The Administrative Services responsibilities include:

- liaison with Treasury Board;
- development of budget preparation guidelines;
- contract arrangements with contracted agencies; and
- operation of the payroll information system for direct service workers.

The Office of Continuing Care's responsibilities for the Home Care Assistance budget include:

- liaison with the Regional Continuing Care Coordinators and with Administrative Services;
- compilation of the Home Care Assistance Budget sub-

mission; and

- monitoring Home Care Assistance spending.

At the regional level, the Regional Continuing Care Coordinators are responsible for preparing regional budget submissions and monitoring regional Home Care Assistance spending against budget.

Since Home Care is an open-ended benefit, available to all those who are eligible as long as the service provider resources exist, there is no significant attempt at any level to actively manage spending to ensure adherence to the budget. The Regional Coordinators note that sometimes when they are exceeding their budgets by substantial amounts they will encourage their case coordinators to step up reassessment activity with a view to closing cases no longer requiring services and identifying opportunities to reduce service levels. However, those responsible for managing the program budget see themselves as having little responsibility for ensuring adherence to the budgets for Home Care Assistance. The Program is open-ended. In this context, the key budget management tasks are to forecast accurately spending for the up-coming year, and to ensure that eligibility criteria for the Program are properly applied and that there is no over servicing of clients.

Exhibit 15, following, presents the amounts requested, those approved and those actually spent on Home Care Assistance. The average annual increase in spending on Home Care Assistance over the past 12 years was about 19%.

Operating Budget

Each Regional Director for Community Health is responsible for an operating budget covering the range of Community Health programs administered on a regional basis. The budget includes salary costs, and operating expenses such as travel and continuing education. In both its

Exhibit 15

Spending request, voted and actual spent for Home Care Assistance in 1974/75 to 1988/89 Fiscal Years

Fiscal Year	Request from Office for Continuing Care	Voted	% annual change in voted amount	Actual	% annual change in actual amount
F.Y.1974/75				$1,752,046.39	
F.Y.1975/76		$4,505,000.00		$4,747,561.81	171.0%
F.Y.1976/77	$6,874,200.00	$6,770,000.00	50.3%	$6,129,605.32	29.1%
F.Y.1977/78	$8,703,700.00	$7,594,300.00	12.2%	$6,731,664.32	9.8%
F.Y.1978/79	$8,747,500.00	$7,507,300.00	-1.1%	$6,889,541.69	2.3%
F.Y.1979/80	$8,196,100.00	$7,727,600.00	2.9%	$8,464,929.35	22.9%
F.Y.1980/81	$8,608,200.00	$8,608,200.00	11.4%	$11,291,757.64	33.4%
F.Y.1981/82	$12,041,800.00	$11,486,800.00	33.4%	$13,610,275.50	20.5%
F.Y.1982/83	$18,211,800.00	$17,452,100.00	51.9%	$16,225,126.27	19.2%
F.Y.1983/84	$18,629,000.00	$20,444,200.00	17.1%	$18,251,457.02	12.5%
F.Y.1984/85	$20,453,400.00	$19,624,600.00	-4.0%	$21,205,685.00	16.2%
F.Y.1985/86	$21,475,300.00	$21,766,500.00	10.9%	$24,955,729.65	17.7%
F.Y.1986/87	$25,828,300.00	$24,671,800.00	13.3%	$32,210,004.96	29.1%
F.Y.1987/88	$29,657,100.00	$33,499,400.00	35.8%	* $36,777,000.00	14.2%
F.Y.1988/89	$41,612,200.00				

* Estimated actual spending for 1987-88

preparation and the regular reporting of expenditures, this budget is broken down by program area. Thus, data are available on regional operating budgets and expenditures for Continuing Care. However, the review found that there is little confidence that spending is attributed accurately to program areas. Regional Directors' budget management efforts were found to focus on ensuring compliance with the overall regional Community Health budgets, and they paid little attention to program by program budget performance.

In 1987/88, the proportion of the total program spending devoted to Continuing Care Program staff and operating costs was 17%. This compares with Ontario where, in 1986/87, 23% of program costs were spent on administration as opposed to patient care.

FINDINGS

The reliance on two separate budgets means that there is not a program budget for Continuing Care. Management responsibility for spending on the Program is fractured. Responsibility for spending on purchased services lies mainly with the Regional Continuing Care Coordinators, while that for program staff and their operating expenses lies with the Regional Directors of Community Health and the line of authority going up to the Assistant Deputy Minister of Community Health. The review found that, in most regions, the Regional Directors focus their budget management efforts on the aggregate Community Health operating budget for the region, paying little attention to the specific operating budgets and expenditures for Continuing Care.

As a result of this situation, data are not readily available on the total cost of the Continuing Care Program. The quality of data on Continuing Care staff and operating expenditures is constrained by the accuracy with which Community Health expenditures are attributed among the various Community Health programs, including Continuing Care.

It also is not clear who is responsible ultimately for spending on Continuing Care. At a corporate level, the Assistant Deputy Minister for Community Health has responsibility for operating expenditures. However, for purchased services (the Home Care Assistance budget), significant responsibilities lie with the Assistant Deputy Minister for Administrative Services as well as the Director of the Continuing Care Program.

A number of the difficulties experienced by the Continuing Care Program in recent years can be linked to the dual budget structure of the Program. Spending on Home Care Assistance has grown dramatically. As was noted in chapter 7, service volume and caseloads also have grown. Given the open ended nature of the program, with services being available to all those in need, there has been no significant management constraint on this growth. However, growth in operating expenditures has been managed much more tightly. Government-wide constraints, in particular limitations on the expansion of staff-year counts, have applied to Continuing Care. As a result, the operating budget appears not to have kept pace with the growth in service volume and caseloads.[10] This has contributed directly to the workload problem and the ramifications for service management discussed in chapter 17.

OPTIONS

Options for Controlling Expenditures

The review findings raise important questions concerning budgetary control for Continuing Care. A number of options deserve consideration.

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[10] Unfortunately the Department was only able to provide data on program salary and operating costs for the years 1985/86 and 1987/88. During this time the proportion of total expenditures going to Program staff salaries and operating expenses declined from 18% to 17%.

It should be recognized that several of the options presented below represent significant departures from the fundamental principles that underlay the Program as it was established originally. In particular, any changes to the principle of universal access to the Program, or introduction of service fees might arouse considerable public reaction.

i) Identifying a single program budget for the Continuing Care Program that includes operating and purchased services expenditures. The principles of program budgeting are well established in the field of public administration. Program budgeting contributes to accountability by linking expenditures and financial management efforts directly to the program outputs. It can facilitate greater efficiency in the allocation of program resources to meet program objectives.

Combining the Home Care Assistance and operating budgets will enable managers to address trade-offs between devoting resources to purchased services versus devoting them to activities carried out by program staff. It also will serve to ensure a more focused management responsibility for the Program and would help resolve the current problems with more than one group of individuals holding management responsibilities. A single program budget also could be structured to include incentives for managers to ensure overall spending remained within budget limits. For example, managers could be allowed to retain a portion of any budgetary surplus for spending in designated areas such as continuing education in the following year (this would be over and above that normally budgeted for). Correspondingly, managers could be penalized in such areas as conferences and continuing education for any deficits incurred.

Changing to a single program budget also could help facilitate two other potential developments in program organization and delivery. The first is the possible change in labour status of direct service workers. If the status of direct service workers is to change to that of government employees (from their current status of self-employed providers), it would be more difficult to justify inclusion of their salary costs in a unique budget identified with purchased services. Though the status of direct service workers has changed to government employees, they are not civil servants nor are they covered by the Civil Service Act. The second possible development is the assignment of a greater degree of management responsibility to the Department's regional offices (see Chapter 12). In this context, discrete program budgets for Continuing Care could be established in each region.

ii) Another option that would serve to control program expenditures would be to establish firm caps on either the volume of program services or on program spending. Such caps could be made specific to particular types of services, such that ceilings were identified for each of: nursing services, homemaker services, therapy services, and so on. In instances where the demand or need for services exceeded the cap, service rationing would be required. A plausible approach to rationing could entail ensuring that all critical/ essential services are provided while diluting the level of non-essential services by a proportion that would correspond to the excess demand. Clients could be given the option of paying for the additional services to meet the level demanded.

An alternative rationing mechanism would be to deliberately institute a form of queuing where certain clients were required to wait for services thereby reducing the overall service utilization levels. Again such a mechanism should be designed to ensure that essential services are provided and that a bias is not introduced against the short-term, acute cases. One advantage of the queuing mechanism would be that it would encourage clients to seek alternative arrangements and to find ways of meeting their care needs which place less reliance on public programming.

Service and budgetary caps have been introduced in other jurisdictions, most notably Alberta, and have led to the adoption of a variety of rationing mechanisms. In the Manitoba context, this option would represent a significant departure from the principles inherent in the original program design. To address concerns in this regard, consideration could be given to establishing caps only for selected services such as housekeeping, while keeping professional services structured on an open-ended basis.

In Alberta, local home care programs have adopted various rationing mechanisms to enable them to live within fixed budgets for services. Some have relied on a service dilution approach. Others have used an arrangement which involved admitting patients at the beginning of each month and closing off admissions as soon as the local program has a full caseload complement. Under the latter arrangement, the program has a smaller proportion of short-term, post-hospitalization clients. Such patients tend only to be served by the program if they are discharged from hospital at the beginning of the month.

It is worth noting also that the principle of capping service volume is not new to the health and social service field in Manitoba. Such service caps are implicit in the delivery of almost all institutional services, including hospital care and personal care homes. Professionals have assumed responsibility for deciding which patients have the most pressing need to make use of the limited numbers of institutional beds available. Even within the Continuing Care Program, there are certain services that are capped, in that there are a fixed number of service slots. This is true of respite care services. For such services, the case coordinators prioritize cases and require clients to wait for services. The same practices occur when there are insufficient care providers to meet all the needs in a particular area.

iii) A third option that could be considered would be to introduce client participation in covering service costs. Such a measure would reduce the level of public expenditure required for services and could potentially contribute towards lower levels of service utilization (thereby further reducing public expenditures) as clients have greater incentives to remain self-sufficient or find alternative services. It is interesting to note that the client survey showed 48% of clients would have continued to stay in their homes even if the program were not available. Of this group, 45% would have purchased their own services. However, such a cost control measure would also represent a significant departure from program principles and might be incompatible with the current public policy values of the Manitoba Government. As with the capping and rationing measures, client participation in costs might be more acceptable if limited to selected services such as housekeeping services (see option ii).

iv) Yet another option to reduce program expenditures would be to cut down on the range of services provided under the Program. However, it is the view of the consultants conducting this review that to eliminate coverage of any single service currently provided by the program would jeopardize the capacity of the Program to maintain individuals in the community. It is interesting to note that Ontario is in the process of introducing a homemaker only benefit (the Integrated Homemaker Program Benefit), some fifteen years after it was introduced in Manitoba. Until recently, home care clients in Ontario could only receive homemaker services in conjunction with professional services (nursing, Physiotherapy and Occupational Therapy). Part of the rationale for bringing in the homemaker only benefit was to prevent instances where individuals were being given the professional services simply to qualify them for home making services. Early data, however, indicate that the new program benefit has not led to a decreased use of professional services. Rather, in the course of assessing clients for the homemaker only benefit, additional clients are being found who need professional services.

Having considered these various options, the most promising option in the Manitoba context appears to be one that involves capping budgets on a regional basis. This would be consistent with the notion of regional program budgets, but it would also entail setting fixed bounds on regional program spending. By placing caps at the regional, rather than the provincial, level, it will be possible to achieve a greater degree of responsiveness to local needs while achieving the cap limitations. The administration of a province-wide cap, on the other hand, is more likely to appear arbitrary in its application.

Exhibit 16 at the end of this chapter summarizes the budgetary control findings.

Exhibit 16

SUMMARY FINDINGS: BUDGETARY CONTROL

ISSUES/CONCERNS	IMPLICATIONS	OPTIONS/SOLUTIONS
1. Program expenditures split between two budget areas: Home Care Assistance for purchased services; and the Community Health operating budget for staff and other program expenses	. no program budget and no focus of responsibility for program spending . failure to manage Continuing Care Program as a unified program . Home Care Assistance spending and service volume, are placing heavy demands on resources to manage the services . workload problem for Program staff	. regional program budgets that comprise both operating and Home Care Assistance spending
2. Spending on purchased services is open-ended	. rapid growth in program service volume . spending on program services routinely exceeds levels budgeted for	. give consideration to: . caps on service volume or service spending . queuing for client services . client participation in costs of selected services . reduced range of services under the program

BUDGETARY CONTROL - RECOMMENDATIONS

1. THE DEPARTMENT SHOULD DEVELOP REGIONAL PROGRAM BUDGETS FOR REGIONAL CONTINUING CARE THAT COMPRISE OPERATING/STAFF AND HOME CARE ASSISTANCE SPENDING. THESE BUDGETS SHOULD BE MANAGED BY REGIONAL STAFF REPORTING TO THE REGIONAL DIRECTORS. THE OFFICE OF CONTINUING CARE SHOULD BE CONSULTED IN THE PREPARATION, APPROVAL AND ONGOING MANAGEMENT OF THESE BUDGETS. SUCH CONSULTATION SHOULD BE FACILITATED BY MECHANISMS TO ENSURE THE OFFICE OF CONTINUING CARE'S INFORMATION NEEDS AND CONCERNS REGARDING REGIONAL OPERATIONS ARE TAKEN INTO CONSIDERATION (E.G., EMERGING HEALTH NEEDS, CHANGES IN TECHNOLOGY AND PROVINCE WIDE POLICY INITIATIVES).

2. THE PROGRAM SHOULD REQUIRE REGIONAL PROGRAM MANAGERS TO MANAGE THEIR BUDGETS MORE ACTIVELY AND TO STAY WITHIN APPROVED LEVELS AND SHOULD GIVE PROGRAM STAFF GREATER DISCRETION OVER SERVICE LEVELS PER CLIENT (I.E., PERMITTING DILUTION OF SERVICES) IN ORDER TO ACHIEVE BUDGET TARGETS.

3. THE PROGRAM SHOULD GIVE CONSIDERATION TO INTRODUCING MEASURES THAT WOULD SERVE TO ENCOURAGE CLIENTS TO MEET THEIR NEEDS THROUGH THEIR OWN RESOURCES (E.G., USER FEES, WAITING PERIODS PRIOR TO RECEIVING NON-PROFESSIONAL SERVICES, USER FEES DURING THE INITIAL PERIOD OF SERVICE AND LIMITING HOURS IN WHICH SERVICES ARE PROVIDED).

11. PROGRAM PLANNING AND FORECASTING DEMAND

PROGRAM PLANNING

The review identified the need for a more systematic program planning process for the Continuing Care Program. Although the Office of Continuing Care currently undertakes a broad range of planning tasks, there is a need for a more structured and formalized process. Such a process would:

- serve to ensure that relevant information is brought to bear on the forecasting exercise;
- ensure that the Program is kept up-to-date on proposals and developments for other parts of the health care system;
- analyze and assess the impacts of external trends on the Continuing Care Program;
- enable the Program to take steps to respond to external trends and better forecast changes in service needs; and,
- provide means of communicating anticipated changes in the program environment and proposed program responses to program managers in the regions.

Specific procedures and measures that would contribute to such a planning process include:

- establishing a formal planning function in the Office of Continuing Care;
- developing a data base on client service and external information

that will meet the Program's information needs for planning, noted in chapter 17 and the Kanes' report (pps. 31-32);

- annual program planning sessions with the Office of Continuing Care staff and all the Regional Continuing Care Coordinators participating; and,

- preparation of a program plan that is updated each year. This plan would include an assessment of the internal and external environments and would outline new directions to be taken by the Program.

A planning function in the Office of Continuing Care would involve hiring a Planning Information Officer who would report to the Director of Continuing Care. Job functions would include the following tasks:

- Identifying all data bases of relevance to planning for the Continuing Care Program, including:

    - Service volume and service mix data.
    - Program financial data.
    - Data on other long-term related service systems (e.g., hospitals and institutional care).
    - Demographic data.
    - Other needs related data (e.g., morbidity, mortality, social supports).

- Developing or assisting development of data bases where there are gaps in currently maintained data (e.g. data on client health status, see page 40).

- Assembling studies, policy analyses, reports of relevance to program planning for continuing care, including literature from other jurisdictions.

- Preparing routine statistical reports of key areas of program activity and performance. The content of such reports should be worked out in consultation with senior departmental management.

- Preparing periodic thematic reports that address current program planning issues. Examples of such reports might include emerging demands (e.g., hospital replacement, AIDS, palliative care) or other issues (e.g., availability of professionals, growth in service volumes).

- Preparing material for regular program planning meetings with management and assisting senior management in identifying and analyzing the implications of major planning options.

- Preparing materials for and coordinating regular program activity and expenditure forecasting exercises (see next part of this chapter).

The Planning Information Officer will have overall responsibility for the management of program planning data. While it is unrealistic to think that such data could be consolidated in a single unified data base, the officer would be responsible for ensuring that the full range of data that are required are available and, where appropriate, that different data bases yield compatible data (i.e., use the same definitions, time periods, categories, etc.).

It is critical that the Planning Information Officer be responsive to the information and planning needs of senior management. The job role is to facilitate and support program planning decisions by senior departmental and program management. The individual should not be expected to plan independently from management. It is also critical that reports and information produced by the planning officer are packaged in a manner that is easy for managers to read and digest. There should be extensive reliance on graphic presentation of data.

FACTORS INFLUENCING DEMAND FOR SERVICES

Spending on Home Care Assistance has persistently exceeded levels forecasted and budgeted. In large part, this is due to the complex range of pressures that continue to drive the demand for such services. These pressures include the following:

- Changing Demographics. The elderly, especially the older elderly make much greater use of Home Care than the non-elderly. This means that the program has been affected particularly by the growing number of elderly in the population. This trend will persist. Statistics Canada has projected that the number of persons 65 and over in Manitoba will grow by 36% between 1987 and 2006. The number 75 and over will increase by 70% over the same period.

- Changing Public Expectations. Public expectations of the health care system are changing. The public is increasingly coming to demand high quality care, and care that gives full consideration to the quality of life. Concerns about the acceptability of institutional care have contributed to pressure for more comprehensive services on an in-home basis, as well as services that will lessen the burden placed on family care givers. One trend in consumer preferences that is having a particular impact on the Continuing Care Program has been the rapid increase in the number of patients, and their families, who would prefer they die at home rather than in a hospital.

- Changing Patterns of Hospital Use. Recent years have seen a great increase in reliance on ambulatory forms of hospital care. There also has been increasing reliance on Home Care as a means of extending care following hospitalization. As these trends continue, greater demands are being made for the provision of care on an in-home basis. Additional evidence of the need for more community based services is provided also by the presence in most acute hospitals of patients whose discharge is delayed for lack of appropriate community arrangements;

- Supply of Institutional Long-Term Care. The availability of nursing home and other institutional long-term care beds has declined in relation to the population "at risk". Evidence of this is provided by the significant increases that have occurred in the average age of admission to personal care homes (i.e., 80.8 years of age in 1980/81 and 84.3 in 1987). If we assume that clients have been placed appropriately in personal care homes, it is plausible to conclude that patients who might, in previous times, have been institutionalized are now living in the community, frequently with the assistance of the Continuing Care Program;

- **Emerging Patterns of Illness**. There is evidence that an increasing proportion of illness and disability is accounted for by chronic diseases of long-term duration, rather than acute illnesses. About nine-tenths of the years of impaired health experienced by individuals are due to various categories of long-term disability.[11] Such trends point to the importance of rehabilitative approaches to care and the need for community services that enable individuals to live as independently as possible within the constraints of such impairments.

- **Application of Technology**. Recent years have seen dramatic changes in the application of technologies that enable clients to be treated and cared for on an in-home basis. They have increased the range of clients for whom home care is a feasible alternative, and greatly increased the number of clients requiring complex, resource intensive forms of home care, for example, intravenous chemotherapy and antibiotic therapy, enterostomal therapy, Total Parenteral Nutrition (T.P.N.), and palliative care for AIDS and cancer patients.

- **Program Establishment**. In the initial years of the Program, its services were not fully understood and appreciated by the public. It is likely that increasing public awareness of the Program has accounted for a large part of the growth in demand. It would be reasonable to assume that there is now a mature awareness/demand for the Program and that this will be a less significant element of future program growth.

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[11] Wilkins and Adams, op.cit., pp. 73

These trends and pressures have all contributed to the growing demand for services from the Continuing Care Program. From a practical perspective, program managers need a method for taking into account the key factors influencing service demand and allowing them to accurately forecast service demand for the upcoming budget year as well as the likely increases in demand over a longer term planning horizon of up to five years. Such forecasting capabilities are an essential foundation for proper budgeting and planning.

CURRENT FORECASTING METHOD

The current budget preparation process requires program managers to prepare budget estimates for the upcoming year. In the case of both the staffing/operating budget and the Home Care Assistance budget, estimates should reflect projected service growth and changes in the mix of services. However, managers preparing such budgets receive inadequate direction on how to forecast changes in service volume and service mix. As a result, managers tend to rely on their own individual approaches to forecasting. The forecasting methods that are followed, thus, lack any consistency across regions. In addition, many managers are lacking management experience and training to enable them to perform these tasks well. In the case of the regional Home Care Assistance budgets, they are prepared at the regional level by the Regional Continuing Care Coordinators. Our review found that three of the ten regional coordinators had been in their current positions less than two years. Almost all these coordinators have professional training as social workers and lacked any formal management training.

OPTIONS

Desired Forecasting Methods. In developing a demand forecasting method for Continuing Care, steps should be taken to ensure that it has the following attributes:

- service utilization in the previous year should provide the base level for forecasts;

- projected population growth by age group along with data on current per capita utilization levels by age group should be used to estimate the impact of demographic change;

- other potential developments should be systematically assessed and their likely impact on Continuing Care demand should also be factored into the forecasts. These would include:

    - changes in government policy;

    - changes in program eligibility, controls on service utilization;

    - changes in the availability and deployment of other health and social services, particularly hospitals and personal care homes;

    - trends regarding the mix of patients (e.g., long-term vs palliative vs hospital replacement);

    - changes in patterns of family care/responsibility for dependent relatives;

    - any technological development likely to be implemented in the upcoming period;

    - any new services being introduced (e.g., respite care, day care, meals-on-wheels, not-for-profit house cleaning, etc); and,

- emerging patterns of illness (e.g., AIDS).

Additional factors that will affect future costs, over and above forecast service growth, include:

- changes in staff or provider mix arising from recruitment, promotion, training/upgrading; and,

- changes in staff salaries, and provider payment rates.

It is important to emphasize that such a forecasting process will be of little value unless it is able to make use of comparable forecasting done for other health care sectors, particularly for hospitals and personal care homes. This point is underlined again in the Kanes' report:

> "At a very basic level, it would be useful for planning and evaluation to integrate information about the use of personal care homes and hospitals with the use of home care on the client level, something that is currently very difficult (although it has been done in Manitoba in a research context). Such information would make accountability in the system more possible."

In introducing a new forecasting method for budgeting and planning, the following measures should be adopted to ensure its full implementation and uniform application:

. a set of explicit forecasting instruction/guidelines should be prepared for inclusion in the budget preparation packages. These instructions/guidelines should be pretested on a small sample of program managers to ensure that they are clear and not ambiguous. Training sessions or materials to prepare new managers for their budget preparation and budget management responsibilities should include a review of these instructions/guidelines;

. standardized forms should be prepared for use in developing forecasts. These forms would ensure that the established formats for estimating demographic impacts on service utilization are followed and that other relevant factors are taken into account. The forms will also record key assumptions used in preparing the forecasts. The forms will be included in budget submissions and will provide a basis for checking that the standardized forecasting method was followed and for verifying the actual calculation and adjustments used to arrive at the forecasts.

Exhibit 17, at the end of this chapter, summarizes the review findings related to forecasting demand.

Exhibit 17

SUMMARY FINDINGS: FORECASTING

ISSUES/CONCERNS	IMPLICATIONS	OPTIONS/SOLUTIONS
. lack of a practical and consistently used method for forecasting service demands/needs	. poor forecasts of future services volume . services and expenditures exceeding budgets	. develop a practical, robust method for forecasting service growth and identifying emerging service trends that can be used consistently across all regions
. lack of program planning process	. failure to anticipate changes in the external environment . lack of long-term direction for program managers	. establish a planning function in CCC

FORECASTING DEMAND AND PROGRAM PLANNING - RECOMMENDATIONS

1. THE OFFICE OF CONTINUING CARE SHOULD DEVELOP A PRACTICAL, ROBUST METHOD FOR FORECASTING SERVICE GROWTH AND TAKING ACCOUNT OF EMERGING SERVICE TRENDS. THIS METHOD SHOULD BE USED CONSISTENTLY ACROSS ALL REGIONS.

2. A FORMAL PLANNING FUNCTION SHOULD BE ESTABLISHED IN THE OFFICE OF CONTINUING CARE. IT SHOULD ENTAIL THE APPOINTMENT OF A PROGRAM PLANNING OFFICER. SPECIFIC RESPONSIBILITIES WILL INCLUDE ORGANIZING PLANNING SESSIONS WITH REGIONAL CONTINUING CARE COORDINATORS, LIAISON WITH MHSC, DEVELOPMENT AND ANALYSIS OF PLANNING DATA BASES.

12. MANAGEMENT ACCOUNTABILITY

BACKGROUND

The Continuing Care Program's organization is characterized by a line program management responsibility that is integrated in the Community Health Services Division. There is also a functional relationship between the regional staff administrating the program and a corporate level Directorate, the Office of Continuing Care. The Office has a variety of responsibilities commonly associated with functional program directorates, including: setting policies; establishing guidelines and standards for program services; monitoring compliance with standards; continuing education; and consultation. The Office has another very important responsibility, that of managing the Home Care Assistance Budget for purchased home care services (this responsibility is discussed more fully in chapter 14 of this report). Exhibit 18, following, presents the current organizational structure for the Continuing Care Program.

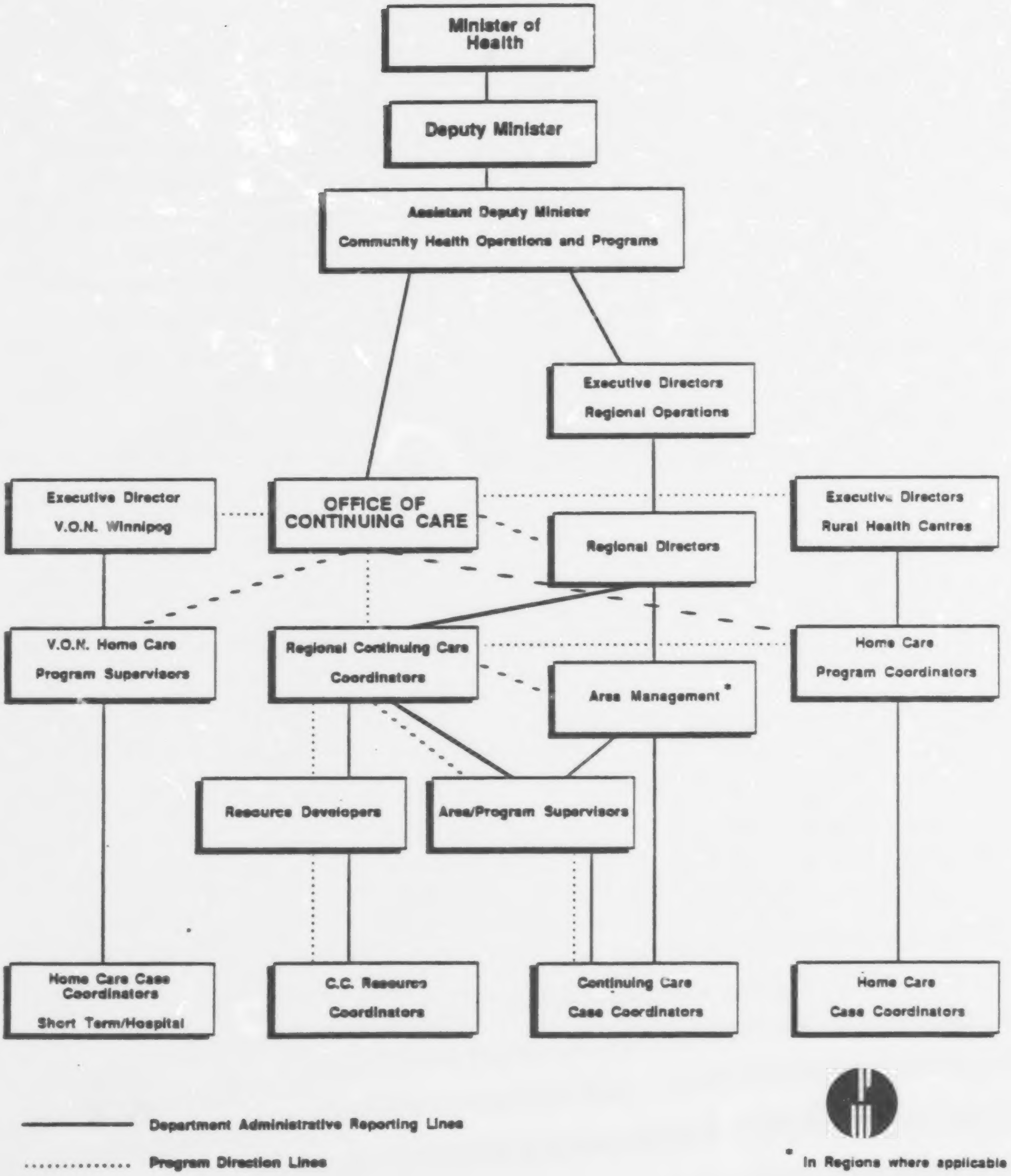
FINDINGS

In reviewing the program management, we concluded that management responsibility for the Program was diffuse. Too many organizational groups of individuals share authority and control of program operations and the line managers lack the authority, resources and, in some instances, the skill and experience to assume management responsibility for the Program. This conclusion stemmed from three important observations:

- Lack of Regional Financial Management Resources. Regional Directors of Community Health Care have limited access to financial management expertise. There are no financial officers located in regional offices. Financial management tasks at the regional level are generally left in the hands of clerical staff.

Exhibit 18

Continuing Care Organizational Structure
1986


Minister of Health
Deputy Minister
Assistant Deputy Minister
Community Health Operations and Programs
Executive Directors
Regional Operations
Executive Director
V.O.N. Winnipeg
OFFICE OF CONTINUING CARE
Regional Directors
Executive Directors
Rural Health Centres
V.O.N. Home Care
Program Supervisors
Regional Continuing Care
Coordinators
Area Management *
Home Care
Program Coordinators
Resource Developers
Area/Program Supervisors
Home Care Case Coordinators
Short Term/Hospital
C.C. Resource
Coordinators
Continuing Care
Case Coordinators
Home Care
Case Coordinators
Department Administrative Reporting Lines
Program Direction Lines
* In Regions where applicable

- Role of Administrative Services. The Administrative Services Division has been given an expenditure management role that goes beyond the support and financial systems management role that is more typical of corporate level finance and administration functions. The Government of Manitoba's Financial Administration Manual requires that each department's executive financial officer maintain direct control of departmental financial systems (See Exhibit W). In part, this role has been precipitated by the lack of financial resources in the line management groups, particularly in the regions. It also reflects a lack of confidence in the administrative/financial skills of line management on the part of Administrative Services officials. However, it is our view that the current role of Administrative Services is highly unsatisfactory. It serves to undermine the decision making authority and responsibilities of line management. It also means that an important element of program management is in the hands of officials who are unfamiliar with program operations and the program environment.

- Budget Responsibilities. Chapter 14 discussed the fractured arrangements for managing budgets associated with the Continuing Care Program. This situation clearly contributes to the diffusion of program management responsibilities. Regional Directors of Community Health have line responsibility for the Continuing Care Program and Program staff in their regions. However, their involvement in the Home Care Assistance budget process is minimal, even though it is the vehicle for paying for almost all Home Care services provided to clients.

The current situation is the worst of two worlds. Management responsibility and financial authority come together neither at the corporate nor at the regional level. Our review found that the diffuseness of management responsibility for the Program significantly impaired management effectiveness and accountability. Specific aspects of management that are affected include:

- Program Planning. Several organizational groups have a stake in good program planning including line managers, the Office of Continuing Care and Treasury Board. Good program planning would facilitate better expenditure forecasting, improved coordination of services, and greater responsiveness to the demands and needs of clients. Each of the three groups mentioned above possess important information of relevance to program planning efforts. Unfortunately, under the current structure, there are obstacles to them collaborating towards this end. Interaction between Regional Directors and the Office of Continuing Care tends to occur largely through the Regional Continuing Care Coordinators. Interaction between the Office of Continuing Care and Treasury Board is mediated by Administrative Services.

- Management Decision Making. The diffuseness of program responsibilities means that management decision making can be cumbersome and, at times, involves decisions being made by officials with little understanding and information on program operations and the program environment. This problem is particularly true of the involvement of Administrative Services. Another example of cumbersome management processes that impede accountability occurs in the area of staffing levels. Although regional Continuing Care staff report to the Regional Directors, it is the Office of Continuing Care that prepares and presents any proposal for new staff years and which allocates such staff years among regions.

- **Financial Control**. Administrative services have the financial management function largely as their exclusive responsibility. This separation and distancing of the financial and the line management functions weakens the level of financial control over the Program.

OPTIONS

The problems described above indicate the need for several changes in the Program organization and management:

- **Regional Financial Function**. One measure that would address difficulties identified in this chapter would be to establish a regional financial function that involved at least one financial officer reporting to each Regional Director. The officers would have a functional reporting relationship to the corporate finance and administration group. Such a measure would address concerns about the lack of financial resources at the regional level and would also bring the financial function into closer contact with day-to-day program operations. The development of regional financial functions would have significant implications for the current Administrative Services Division. Numerous activities and responsibilities currently at the corporate level would be transferred to the regions. Such responsibilities would include: financial planning and reporting; management of financial reporting systems; contract administration; and, financial controls. This option would also have implications for regional staff year allotments, requiring at least ten new regional positions - some of these could be offset by savings at the corporate Administration Services level.

- **Improved Line Management Capabilities**. Many of the individuals with line management responsibilities in the Program are promoted from staff level positions. As a result, many of them lack formal preparation in relevant administration topics. Clearly, if greater program management responsibilities are to be included in these positions, measures have to be taken to ensure that the individuals involved have appropriate management training and receive appropriate supervision and guidance on an ongoing basis. Future recruitment initiatives could emphasize finding people who already possess the required skills.

- Program Planning Mechanisms. Mechanisms should be introduced to facilitate improved program planning, to ensure that appropriate organizational groups are represented in such a process and to enable all relevant data to be used. This could include the establishment of a Program Planning Committee with clearly defined program planning responsibilities. Clearly, such a committee would have to be responsive to the policy making levels in the Department.

- Regional Program Budgets. As discussed in Chapter 14, overall program management and accountability would be greatly facilitated by developing regional program budgets that covered both purchased services (Home Care Assistance) and program operations.

Exhibit 19, at the end of this chapter, summarizes the findings related to Program Organization and management accountability.

Exhibit 19

SUMMARY FINDINGS: MANAGEMENT ACCOUNTABILITY

ISSUES/CONCERNS	IMPLICATIONS	OPTIONS/SOLUTIONS
. Diffuse management responsibilities for the program arising from: . lack of regional financial management resources . over concentration of expenditure management responsibilities in the Administrative Services Division . fractured budget management responsibilities	. inability of program managers to effectively manage the program . dependency on Administrative Services regarding financial management issues . lack of opportunity for line manager to develop competence in the area of financial management	. regional financial function . training existing line managers in financial administration and requiring competence in this area for any new appointments . program planning mechanisms . regional program budgets

MANAGEMENT ACCOUNTABILITY - RECOMMENDATIONS

1. THE DEPARTMENT SHOULD ESTABLISH A FINANCIAL FUNCTION FOR EACH REGION. IT SHOULD ASSUME RESPONSIBILITY FOR FINANCIAL PLANNING AND REPORTING, MANAGEMENT OF FINANCIAL REPORTING SYSTEMS, CONTRACT ADMINISTRATION AND FINANCIAL CONTROLS.

2. THE DEPARTMENT SHOULD UNDERTAKE TO TRAIN EXISTING REGIONAL MANAGERS IN FINANCIAL ADMINISTRATION. COMPETENCE IN FINANCIAL ADMINISTRATION SHOULD BE MADE A REQUIREMENT FOR NEW APPOINTMENTS TO REGIONAL FINANCIAL POSITIONS.

13. STAFF TRAINING

BACKGROUND

The review addressed the adequacy of staff skills and training to perform their responsibilities under the program.

FINDINGS

There were two major findings relative to staff training identified in the review:

- program staff lacked essential skills and training in specific program areas; and,
- there was an inadequate level of in-services for regional program staff.

Each finding is discussed further in the following sections. The findings are summarized in Exhibit 20 at the end of this chapter.

ESSENTIAL SKILLS AND TRAINING LACKING

Three specific areas of training inadequacies were noted across the Province:

- Office of Continuing Care staff, Regional Directors and Regional Continuing Care Coordinators lacked essential budget training;
- Office of Continuing Care staff, and Regional Continuing Care Coordinators lacked program planning skills; and,
- Non-baccalaureate case coordinators lacked assessment skills and theoretical framework for community health care.

Generally, Program staff did not feel competent in the area of budget preparation and control. Their educational background and job experience did not prepare them for the financial responsibility of the position, yet these individuals command budgets between one and forty million dollars.

The lack of essential budget skills can mean inadequate budget preparation:

- uncertain of what financial data is required;
- uncertain of financial data relationships;
- generally unprepared, therefore have not made the necessary requests for required financial and program data;
- reports are not completed accurately on first submission; and,
- misinterpretation of budget task and budget expectations exist.

The result is time spent clarifying the budget process and in data collection.

Another implication of the lack of budgetary skills and training is the difficulty program staff experience in attempting to justify budget variances. Again, time is spent preparing and submitting variance explanations only to discover they are invalid or unacceptable.

An apparent solution is to arrange budget training sessions for staff with financial responsibilities. This training should be a basic requirement for new program staff with budget management tasks. It is our understanding that the Regional Continuing Care Coordinators have asked for and received one course in budgeting. Although they stated the course was valuable they feel more training is essential.

The second program area where staff lack essential skills and training is with program planning. Although the absence of a provincial forecasting model accentuates the problem, generally, staff are inexperienced with program planning models. As a result they cannot forecast accurately and systematically program needs; "guesstimates" are offered on the basis of historical knowledge. Given that 30 percent of the Regional Continuing Care Coordinators and 50 percent of the Regional Directors have been in their current position for less than two years, their ability to "guesstimate" program needs is questionable.

As well, program planning is inconsistent across regions due to the varying levels of experience, skills and program knowledge of the staff involved in the process.

A final implication related to the lack of program planning skills is that program response is reactive not proactive. Client situations exist before action is taken. Take for example, Acquired Immune Deficiency Syndrome (AIDS). Nine clients with AIDS currently are being cared for under the short-term care program yet Continuing Care has failed to identify the projected impact of this disease on Home Care. Calculation of the projected client numbers, their needs and the cost to deliver client services could demonstrate that the appropriate setting of care is an institutional one. If not, policies and procedures to govern the care of these clients (e.g., handling and disposing of body fluids) must be put in place and the information quickly disseminated to all regions and all direct service workers.

This reactive rather than proactive approach could result in:

- precedence establishment before decisions are reached regarding service provision;
- provision of unexpected costly services (i.e. when cost per case is combined with projected number of cases not pre-determined); and,
- unexpected client service demands (e.g., professional staff, equipment, and supplies necessary to care for this clientele at home).

It is evident that education and training related to program planning and evaluation is necessary for Management staff. Course work, seminars, and workshops are just a few methods to provide the necessary planning skills. Furthermore, formal knowledge of planning should be a prerequisite for positions requiring these skills (e.g., Director of the Office of Continuing Care, and Regional Continuing Care Coordinator). An inherent assumption is that program managers have sufficient resources to plan effectively.

The third program area lacking essential skills and training is the area of client assessments. Difficulties encountered in recruiting qualified staff to the North and remote areas results in hiring diploma rather than baccalaureate nurses as case coordinators.

Diploma nurses may lack the advanced assessment skills and community experience found in university nursing programs. The Continuing Care Program does not provide the nurse with the additional training. As a result there may be inadequate emphasis in client care planning on:

- taking advantages of opportunities for client self care (e.g., referring client for occupational therapy assessment, utilizing aids for personal care/safety);

- promoting client independence (e.g., instructions and assistance in personal care); and,

- restoring client functioning (e.g., exercises to work toward improving strength for walking, lifting, moving and so on).

Additional assessment training and community courses would raise the skills of diploma nurses. University distance education courses could also be designed and implemented. A second method of elevating the assessment skills and community knowledge of the diploma case coordinators would be to promote case conferencing. Case conferences are group discussions of complex client cases resulting in the development of a client care plan. The new case coordinator would benefit from the more experienced worker's approach and suggestions.

A third option would be to increase the amount and degree of program supervision for diploma case coordinators. Close supervision allows for discussion of service delivery decisions at an early stage. The final option is to recruit and hire only baccalaureate prepared case coordinators. Clearly, selection of this option eliminates the need for the above three.

Exhibit 20

SUMMARY FINDINGS: STAFF TRAINING

ISSUES/CONCERNS	IMPLICATIONS	OPTIONS/SOLUTIONS
1. Program staff lack essential skills and training in specific program areas		
. OCC Staff and Regional ordinators lack program planning skills	. inability to accurately cast program needs . inconsistent program planning across regions . reactive rather than pro-active planning	. provide education and program planning and coursework . make program planning and evaluation course work prerequesite of position . ensure staffing levels allow staff to spend time on program planning
. non-Baccalaureate case coordinators lack assessment skills and theoretical framework for community health care	. inadequate emphasis in care planning on: . taking advantages of opportunities for client self care . promoting client . restoring client functioning . over servicing . client dependence	. provide additional assessment training and community courses . increase amount of program supervision during first year of employment . promote case conferencing with experienced program staff . advanced assessment and community theory course as employment requisite . hire baccalaureate nurses
2. Inadequate level of inservice	. staff professionally stagnate	. in services to challenge and stimulate . new approach to care . update knowledge base
. low budget and non-priority	. staff morale and work enthusiasm affected	
. workloads deny time for in service	. unaware of new trends and opportunities in health care delivery, therefore unable to prepare for impact	

STAFF TRAINING - RECOMMENDATIONS

1. THE PROGRAM SHOULD DEVELOP AND UNDERTAKE TRAINING PROGRAMS TO ENHANCE THE FOLLOWING AREAS:

   . PROGRAM PLANNING AND EVALUATION SKILLS AMONG OFFICE OF CONTINUING CARE, AND REGIONAL PROGRAM STAFF

   . ASSESSMENT SKILLS AMONG NON-BACCALAUREATE CASE COORDINATORS.

2. MEASURES SHOULD BE TAKEN TO ENSURE THAT RESOURCES ALLOCATED FOR IN-SERVICE TRAINING ARE NOT SACRIFICED AS A RESULT OF BUDGET PRESSURES.

PART V : REVIEW OF OPERATIONS

INTRODUCTION

In this section of the report, Continuing Care Program operations are reviewed. These operations correspond to seven of the review issues. They are:

- Service Coordination (issue number 8 in chapter 2);
- Service Delivery (issue number 9 in chapter 2);
- Intake, Assessment, Panelling (issue number 10 in chapter 2);
- Staff Workloads (issue number 11 in chapter 2);
- Direct Service Workers (issue number 14 in chapter 2);
- Client Services (issue number 12 in chapter 2); and,
- Role of the Victorian Order of Nurses in the Program (issue number 7 in chapter 2).

Each of these issues is described briefly followed by:

- a concise description of the review findings;
- an assessment of potential program implications if findings are not addressed;
- options for addressing the findings; and,
- our recommendation(s) on a preferred option.

These findings, implications, options and recommendations are summarized in Exhibits presented at the end of each chapter.

14. SERVICE COORDINATION

DESCRIPTION

Continuing Care is defined in the Program's policy guidelines as the continuity of meeting care needs for individuals living at home through to temporary absences from home (hospitalization) and placement into care facilities. Services are organized to avoid deterioration and maintain or enhance health. A key requirement in achieving continuity is coordination between those who provide various levels of care: hospitals and personal care homes.

Exhibit 21, following, depicts the interaction between the Continuing Care Program and the two major health care facilities: hospitals and personal care homes.

BACKGROUND

The review was to examine the interface of the Program with other services, in particular hospital and personal care homes. During the review this issue was expanded slightly to include the interface of the Continuing Care Program with other regional community health programs. As a result, service coordination will be addressed within three areas:

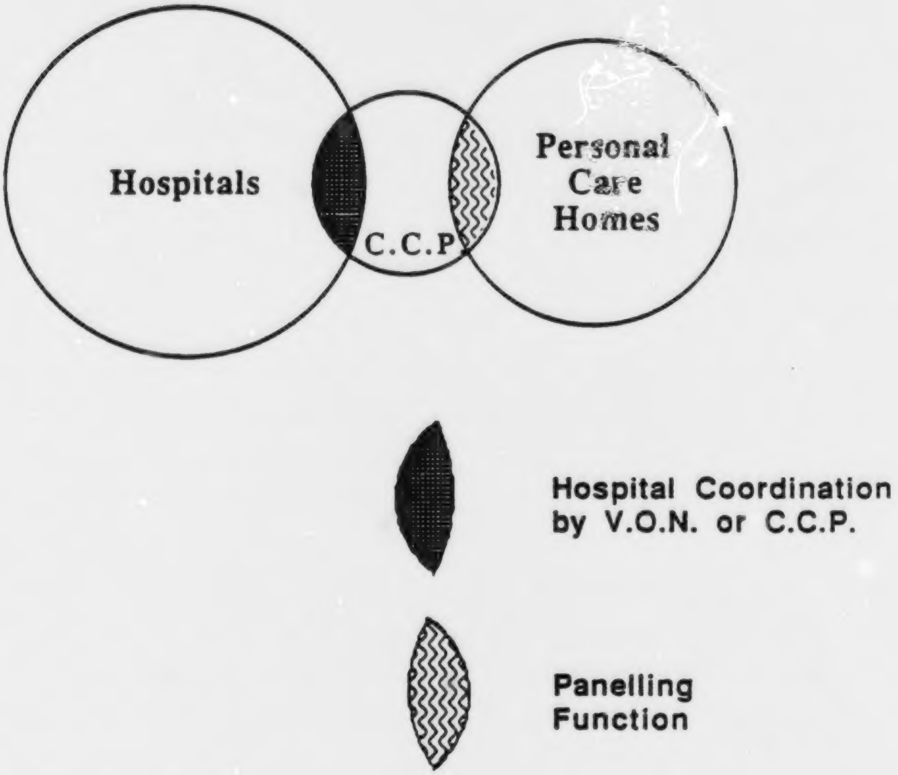
- Continuing Care Program and Hospitals;
- Continuing Care Program and Personal Care Homes; and,
- Continuing Care Program and Other Community Health Programs.

Continuing Care Program And Hospitals

A liaison/coordination relationship exists between hospitals and the Program at both regional and central levels. Regionally, this relationship is intended to ensure the smooth transition of clients from the hospital to the community and vice versa. Coordination between the

Exhibit 21

Relationship of Continuing Care Program (C.C.P.) to Hospitals and Personal Care Homes (P.C.H.)


Hospitals
C.C.P
Personal Care Homes
Hospital Coordination by V.O.N. or C.C.P.
Panelling Function

hospitals and the Program is carried out by the VON in Winnipeg and by case coordinators in some regions. In other regions this role is not carried out (i.e., no one has formal responsibility).

Centrally, service coordination between hospitals and the Program is achieved through:

- discharge planning committees (rural and urban hospitals);
- conjoint planning committee;
- advisory committee on trends and technology; and,
- ad hoc meetings.

Continuing Care And Personal Care Homes

The Relationship between Personal Care Homes and the Continuing Care Program is defined clearly in the Program manual. Regionally, the program staff are responsible for:

- assessing client needs and applications for personal care home;
- establishing assessment panels;
- setting placement priorities; and,
- maintaining waiting lists.

The panelling process and the responsibilities of those involved are discussed in more detail in chapter 16.

The Personal Care Home Division of the Manitoba Health Services Commission (MHSC) maintains working relationships with the Regional Program Staff through the Standards Officers of Personal Care Home and Rural Health Facility Division Staff. The MHSC through the Manitoba Health Services Insurance Act insures care in a Personal Care Home.

Centrally, policies related to the assessment and to the placement/admission are developed jointly by the Office of Continuing Care and the Personal Care Home Division. Ad hoc meetings and/or committees also are established to address specific concerns of coordination.

Continuing Care Program And Other Community Health Programs

Mental health (MH), Mental retardation (MR), Child and Family Services (C&FS) and the Continuing Care Program are some of the community programs delivered by the local regional health offices. Each program has its respective mandate and scope of services. The services are coordinated at the regional level to provide community health and social services to the local residents. This coordination is achieved through management meetings of regional program managers.

FINDINGS

In the area of service coordination, there were two major findings of concern:

- inadequate hospital discharge planning - especially from Winnipeg hospitals; and,

- reliance on the Continuing Care Program to fill service gaps in community programs which are beyond the Program's mandate.

Details in each of these findings are provided below.

Inadequate Hospital Discharge Planning

Case coordinators from all regions expressed concerns about discharge planning practices especially of Winnipeg hospitals and of some rural hospitals which did not have a formal Continuing Care Program hospital liaison.

In their view, clients were discharged who:

- had minimal, if any, education regarding their condition (e.g., diabetics unable to self-administer insulin);
- were promised inappropriate home care services from hospital physicians and nurses (e.g., weekly house cleaning, daily nursing services);
- did not have the necessary supplies/equipment to care for themselves at home (e.g., a new diabetic without insulin syringes);
- were released without the awareness of the community program staff (e.g., client called from his/her home requesting services); and,
- could not be supported at home with local community resources (e.g., nursing staff not available).

Examples of the above nature were identified frequently, however, the bulk of such examples pertained to clients being discharged from the Winnipeg hospitals to local and rural communities. The process of discharge planning from Winnipeg hospitals is discussed in chapter 12.

In our view, problems of the above nature concerning discharge planning could result in several detrimental effects on program clients and the Program itself. These are:

- inappropriate discharges. If an appropriate assessment of local resources is not done, clients may not receive the services they require;

- inadequate client preparation for discharge. This could result in discharged clients being unprepared to assume self care activities. Client deterioration and/or re-hospitalization may occur;

- unforeseen demands on home care. That is, unrealistic and unplanned resource mobilization requests;

- unsafe client situations. That is, clients could be placed at risk until professional resources are put in place; and,

- negative perception of home care. That is, clients/families reacting negatively when services promised are not provided.

In contrast to the above situation, those rural regions which had assigned community case coordinators as the hospital/community care liaison reported experiencing few difficulties with discharged clients in their regions. They were able to prevent the complications of inadequate discharge planning by:

- accurately determining program eligibility for hospitalized clients in advance;

- following client progress from admission to discharge, planning appropriate home care services pre-discharge, knowing available community resources; and,

. ensuring the instruction of activities related to client/family self care.

The community care coordinator/hospital liaison also reported an ability to keep track of clients moving from the community to the hospital (through case finding, meeting with newly hospitalized clients, surveying admission lists and so on). They were then able to notify local program staff of client admissions.

In addressing the concern of discharge planning, a logical option is to ensure that hospital/community liaison positions exist for all major hospitals. This could include new staff year positions in some regions as well as a formalization of existing functions in other regions. In addition, orientation and information sessions should be provided for local hospital staff to inform them of the role and objectives of Continuing Care.

Handouts, videos, and slide tape presentations are just a few methods that could be utilized to orient hospital staff members and potential home care clients to the Program. Once developed, these materials could be circulated to professional associations and consumer advocacy groups.

Pressures to Meet Gaps in Local Services

Resources of the Continuing Care Program are being sought constantly by other programs, specifically for access to day care, respite care, and home care services. The Home Care Assistance budget has come to represent the "deep pocket" for the Community Health program portfolio. Professionals serving other program populations are apt to turn to Home Care as a vehicle for meeting their particular client's service needs when their own program resources are limited.

Attempts to access home care resources results in tensions between community programs and some unauthorized service provisions. Tension is created when Home Care has the necessary resources to meet client needs, yet is unable to provide services because those who need them do not meet program eligibility criteria. Take for example, a mentally retarded individual who might benefit from day care, or whose family requires brief periods of respite. Home care has the necessary resources but the client does not meet eligibility requirements. In some regions, rather than seeing the client and/or family go without, services are provided to the ineligible client. Other regions will not authorize the services. The varying responses to service gaps results in inconsistent client access to services across regions. For example, one region provides services to children with complex care needs even though the Office of Continuing Care has determined them ineligible for program funds. (A committee, however, has been established to determine the locus of responsibility for this group of clients). This inconsistent provision of services across regions also raises a concern of fairness.

To deal with the problems associated with community program service gaps beyond the scope of Continuing Care, the following should be considered:

. the defined Continuing Care Program scope should be enforced through program review and/or caseload review. This would ensure consistent and fair access to services provided by the Continuing Care Program; and,

. Continuing Care Program scope decisions relative to emerging services trends should be addressed (e.g., children with heavy care needs). Methods to disseminate decisions should be in place to ensure that all regions are aware of, understand and enforce these policy decisions.

The Continuing Care Program and Physicians

The terms of reference for this review also raise a question as to whether there are "... potential changes in physicians' patterns of practice that can assist the continuing care program". The review found that the role of physicians in the program was largely limited to that of serving as a source of referral to the program. The field work also indicated that some physicians may not fully understand how home care functions. Experience from other jurisdictions suggests that physicians need to be educated about the role that home care can play in patient care and that they frequently need to be reassured about the quality of care provided under home care. It would appear that increasing rates of referral to home care by hospital physicians have been prompted less by their growing awareness and understanding of the program and more by the necessity of responding to growing pressure on hospital beds. The absence of significant involvement of physicians in the day to day operations of home care raises questions about whether there is a need to more actively involve physicians in patients' home care service planning to ensure that there is greater continuity of care. Our review findings, however, indicate that, when appropriate, Home Care case coordinators obtain information from clients' physicians on care that the clients are receiving under the physicians' direction, including information on any medications they are taking. This information is recorded on the direct assessment form. Further, the review found that, where appropriate, case coordinators would hold case conferences with physicians.

Exhibit 22, following, summarizes the findings, implications and options/solutions concerning service coordination.

Exhibit 22

Exhibit 22

SUMMARY FINDINGS : SERVICE COORDINATION

ISSUES/CONCERNS	IMPLICATIONS	OPTIONS
1. Inadequate hospital discharge planning	. inappropriate discharges . inadequate client preparation for discharge . unforeseen demands on home care . potentially unsafe client situations . negative perception of home care	. hospital liaison role establishment in all regions . orientation and information sessions for hospital staff

2. Community program service gaps beyond defined scope of Continuing Care	. home care perceived as deepest pocket and Regional staff provide services outside program scope
	. inconsistent access to services across regions
	. raises concern of fairness
		. enforce defined program scope through
		  . program review
		  . caseload review
		. prompt program scope decisions and methods of disseminating decisions to meet emerging trends

SERVICE COORDINATION: RECOMMENDATIONS

1. REGIONAL OFFICES SHOULD ASSIGN RESPONSIBILITIES TO SPECIFIC CASE COORDINATORS FOR COORDINATING DISCHARGES AT EACH HOSPITAL. HOSPITALS SHOULD EACH ASSIGN RESPONSIBILITY TO A SPECIFIC STAFF MEMBER FOR COORDINATING WITH THE CONTINUING CARE PROGRAM. IN MANY INSTANCES THIS INDIVIDUAL COULD BE THE HOSPITAL DISCHARGE PLANNER.

2. BOTH THE CONTINUING CARE PROGRAM AND HOSPITAL INDIVIDUALS INVOLVED IN COORDINATION SHOULD PROVIDE ORIENTATION AND ONGOING INFORMATION SESSIONS TO HOSPITAL STAFF.

3. THE OFFICE OF CONTINUING CARE SHOULD CONTINUE TO UNDERTAKE PROGRAM AND CASELOAD REVIEWS AND SHOULD PLACE SPECIAL EMPHASIS ON ENSURING THAT ELIGIBILITY CRITERIA AND SERVICE DEFINITIONS ARE CONSISTENT WITH PROGRAM POLICIES ACROSS ALL REGIONS. IN ADDITION, THE PROGRAM SHOULD REINSTATE THE ANNUAL PROGRAM REVIEW PROCESS IN EACH REGION.

4. THE OFFICE OF CONTINUING CARE AND REGIONAL CONTINUING CARE COORDINATORS SHOULD BE RESPONSIBLE FOR IDENTIFYING EMERGING SERVICE ISSUES AND ENSURING SWIFT PROGRAM POLICY DECISIONS IN RESPONSE.

15. SERVICE DELIVERY

BACKGROUND

The review examined the organizational responsibilities of the Office of Continuing Care and the regional program staff and the client appeal process as they related to delivery of program services. The review also assessed the appropriateness of the mix and level of staff used to deliver program services.

DESCRIPTION

The Office of Continuing Care is responsible for the Province-wide program development, standards, coordination and evaluation of the Continuing Care Program (Policy Guidelines, pp. 5). This Office is staffed by a:

- Director of Continuing Care reporting to the Assistant Deputy Ministry of Community Health Services Division and responsible for providing leadership in policy direction, program development and evaluation for the Continuing Care Program;

- Program Specialist - Resource reporting to Director of Continuing Care and jointly responsible with two other Program specialists for assuring province wide standards and effective delivery of Continuing Care services. Specifically, the resource specialist assists regions and external agencies in the development, management, training and monitoring of resources for the delivery of services purchased or provided by Continuing Care;

- Program Specialist - Nursing, reporting to the Director of Continuing Care and working closely with the other program specialists ensures the province-wide application of program standards, specifically, nursing practice standards. The incumbent also assures effective service delivery;

- Program Specialist - Social Work, reporting to the Director of Continuing Care and also working closely with the other program specialists to ensure province-wide standards and effective delivery of the Program through regional offices, health centres, agencies, hospitals and personal care homes;
- Coordinator of Program Information, reporting to the Director of Continuing Care and responsible for the management and development of the Continuing Care Information System; for financial planning and management for the Office of Continuing Care, and participation in planning and evaluating the Program;
  - Central Registry Coordinator reporting to the Coordinator of Program Information and responsible for the operation and maintenance of the Continuing Care Client Registry as well as maintenance of the program forms systems; and,
  - Clerical Support Staff who provide comprehensive clerical, secretarial/administrative services to the staff in the Office of Continuing Care.

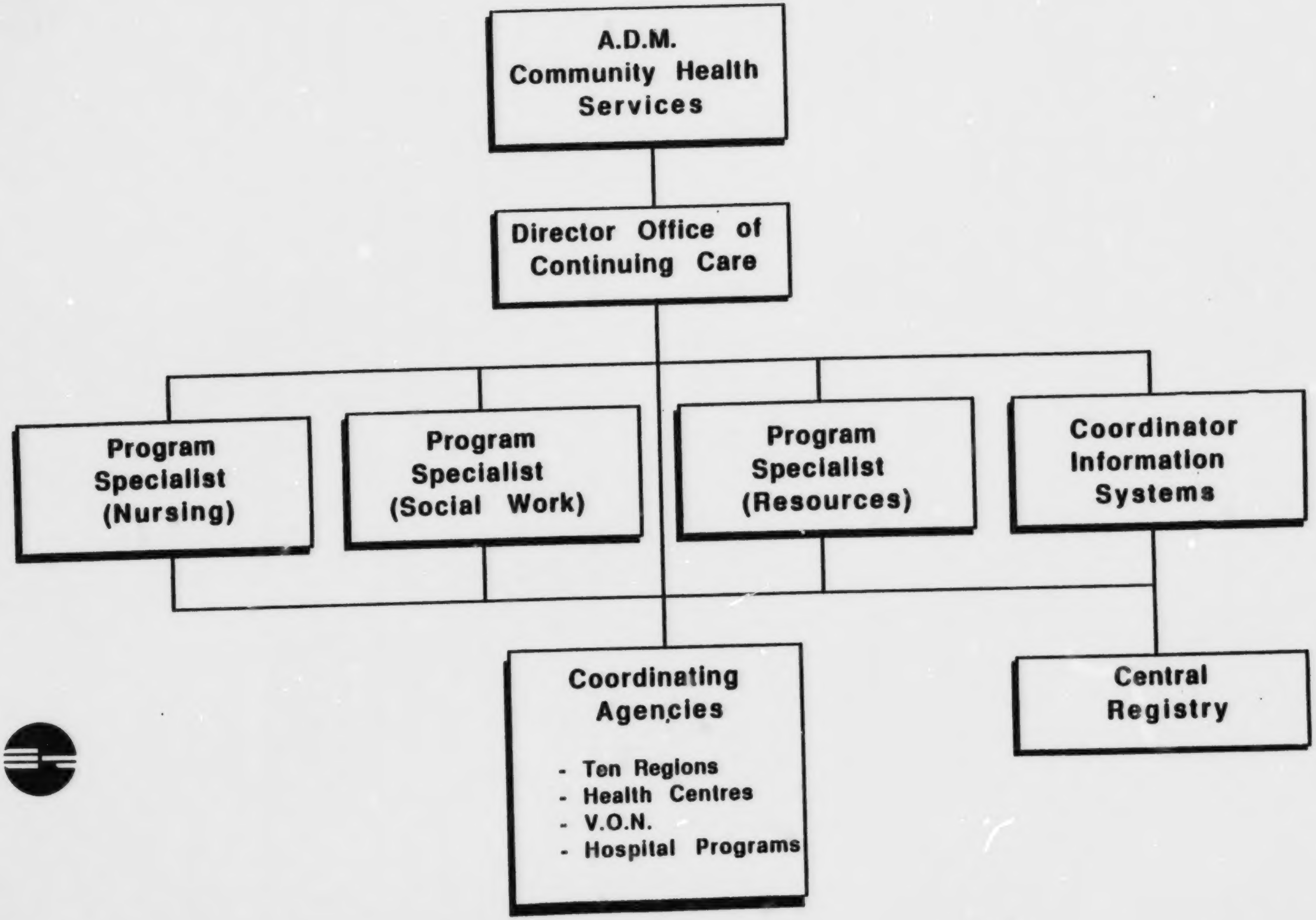
The organizational structure of the Office of Continuing Care is depicted in Exhibit 23, following.

The delivery of the Program is through four types of coordinating agencies. These are:

- regional government offices consisting of ten district service regions for the province;

Exhibit 23

Office of Continuing Care Organizational Structure


A.D.M.
Community Health Services
Director Office of Continuing Care
Program Specialist (Nursing)
Program Specialist (Social Work)
Program Specialist (Resources)
Coordinator Information Systems
Coordinating Agencies
- Ten Regions
- Health Centres
- V.O.N.
- Hospital Programs
Central Registry

- Health Centres operating under a community board to provide Continuing Care services. There are five Health Centre Coordinating Agencies;

- Victorian Order of Nurses (VON), a non-profit agency operating under a private board in the City of Winnipeg. VON is the designated coordinating agency for short-term Home Care (up to 60 days) for the Winnipeg area. Their role is discussed further in Chapter 12; and,

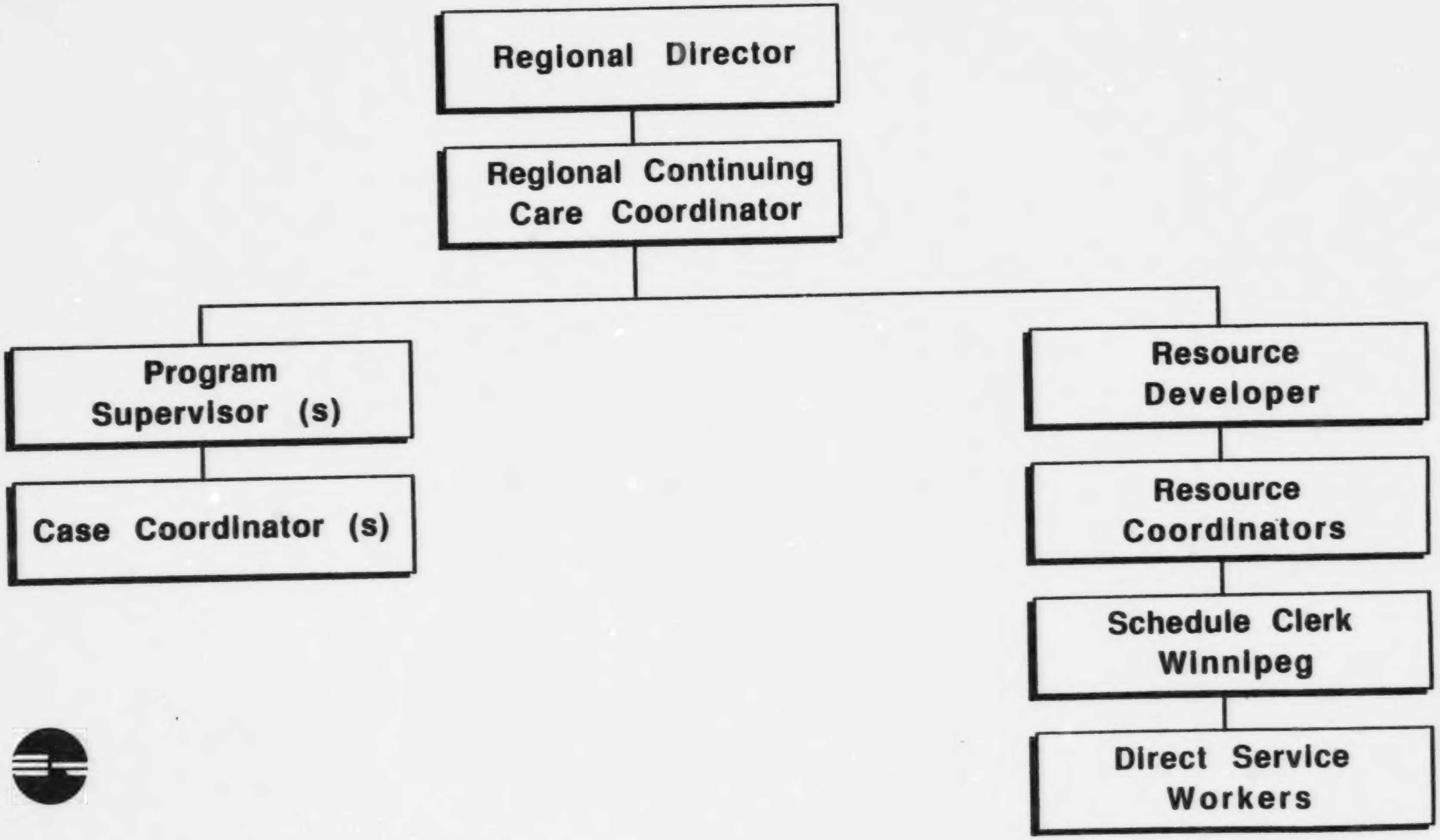
- Hospital Home Care Offices established in hospitals with staff paid for or contracted for by the Program.

The structure and operations of the regional coordinating agencies will be described further. A general regional organizational chart is shown in Exhibit 24, following, although not all regions are structured exactly as shown.

Each region has a Regional Director responsible for the operations within the region and reports to one of the Executive Directors of Operations who, in turn, reports to the Deputy Minister of Health and Deputy Minister of Community Services. The Regional Continuing Care Coordinator, reporting to the Regional Director, is responsible for the planning, implementation and coordination of the Continuing Care Program in the region including the development and management of program staff and resources. Under the direction of the Regional Continuing Care Coordinator, Program Supervisors assume responsibility for ensuring effective delivery of program services in a specific geographic service area.

Exhibit 24

Regional Offices
Continuing Care Program
General Organizational Chart *


Regional Director
Regional Continuing Care Coordinator
Program Supervisor (s)
Case Coordinator (s)
Resource Developer
Resource Coordinators
Schedule Clerk Winnipeg
Direct Service Workers

* Not All Regions Adopt This Organizational Structure

The case coordinator reporting to the Program Supervisor and ultimately the Regional Continuing Care Coordinator functions as a member of a multi-disciplinary team and is responsible for determining program eligibility. The case coordinator assesses the need for care at home or in a personal care home and coordinates the delivery of Program services based on Program guidelines.

The resource developer, reporting to the Regional Continuing Care Coordinator is responsible for the development, organization, maintenance and evaluation of Program services and resources. The resource coordinator, under the direction of the resource developer and ultimately the Regional Continuing Care Coordinator, is responsible for the recruitment, orientation, matching assignment, supervision and evaluation of direct service workers and volunteers.

In the three Winnipeg regions, the scheduling clerk is responsible for the scheduling and assigning of direct service workers, for record keeping, for verification of worker time sheets and for monthly direct service statistics.

Direct Service Workers include professional and non-professional staff. Professional staff are Registered Nurses (RN) and Licensed Practical Nurses (LPN). Non-professional staff are Home Care attendants (HCA) and Home Support Workers (HSW).

Before proceeding to the review findings regarding service delivery, the client appeal process will be described. First, the term client appeal is not utilized. Rather, the term used is "complaint". Second, there are informal and formal complaints. An informal complaint is one that "lacks identification and/or specific information" and a formal complaint is when clear information is available and the complainant has signed a complaint form.

The complaint form captures information regarding the incident or complaint. This information includes:

- the nature of the incident;
- the date the incident occurred;
- who reported the incident;
- the location of incident;
- who has access to client's home;
- a description of the incident;
- to whom the incident was reported; and,
- the disposition of the complaint form.

Both informal and formal complaints/incidents are to be investigated by the case coordinator and appropriate action taken. Complaint forms, when complete, are forwarded to the Regional Continuing Care Coordinator for further review.

FINDINGS

There are five major findings relative to service delivery within the Continuing Care Program:

- variations exist in regional organizational structures;
- some regions lack Program Supervisors;
- Case Coordinators consider different sets of factors in service decision making;
- some clients are unaware of the appeal process; and,
- concerns surrounding the case coordinators role in direct service work.

Variations in Regional Organizational Structure

Regional organizational structures are determined by regional staff and vary across the province depending on the needs, resources and number of staff in the region. There are, however, a number of variations that have to be addressed:

- Some Regional Continuing Care Coordinators have competing responsibilities. That is, in a minimum of three rural regions not only was the Regional Continuing Care Coordinator responsible for Program management, he/she was also responsible for managing a district office within the region. The dual responsibility leads to inconsistent and, at times, inadequate program management. In fact, in one region the management of the district office took almost 80 percent of the Regional Continuing Care Coordinator's time leaving only minimal time to manage the Continuing Care Program. The above example demonstrates that dual responsibility undermines Regional Coordinators' commitment to program management. District Office management took precedence.

- In two regions, continuing care staff are reporting to non-Continuing Care Program staff. That is, case coordinators and other program staff are reporting to and are supervised by Regional Community Health Program Supervisors responsible for the district office in which they work. The district office manager may not be the Regional Continuing Care Coordinator or a Program Supervisor. As a result, Continuing Care Program staff lack direction on program issues, policy and program content. In fact, rather than investing time to seek out the Regional Continuing Care Coordinators, case coordinators are making their own decisions regarding Continuing Care Program policies and acting on their interpretations.

. One region lacked the resource development function. The resource developer position did not exist resulting in a deficient control of the resource coordination function. In time, this leads to short comings in identifying and establishing service provider resource options.

To deal with variations in the organizational structure across the Province it is suggested that minimal organizational requirements be established in each region. These would include:

. a full time Regional Continuing Care Coordinator to ensure adequate regional program management;

. Continuing Care Program staff reporting to Continuing Care Program supervisors to ensure appropriate direction on program issues and accurate information regarding program content; and,

. a requirement for a resource developer in each region to ensure effective control of direct service workers in the region.

Regions Lacking Program Supervisors

Lack of Continuing Care Program Supervisors in four rural regions has resulted in diminished case coordinator supervision in those regions. This situation is further aggravated in two regions where the regional Continuing Care Coordinators without supervisors are also responsible for the Continuing Care Program as well as a district office. Performance appraisals of case coordinators are not done and the number of caseload reviews conducted in these regions are reduced. As well, caseload problems are not solved in a timely fashion. The lack of supervisors reduces the opportunity to identify and solve ineffectual case management practices of case coordinators.

It is clear that an adequate number of program supervisors is essential to monitoring case coordinator service delivery decisions in addition to providing sound regional program management. A staffing ratio of one supervisor to eight case coordinators is recommended for two reasons. First, the usual effective management span of control ranges from five to ten staff. Eight assures a reasonable degree of effective control. Second, in the Ontario Home Care Program, a ratio of one supervisor to ten case managers is standard. Since Ontario case managers cannot order services without a physician's referral, there is an inherent check on the amount and type of services provided by their Program. In Manitoba, a physician's referral is not necessary and case coordinators are relatively free to provide services to meet client need. Therefore, a ratio of one supervisor to eight case coordinators should provide the management structure for appropriate selection and delivery of Program services.

Case Coordinators Affected By Different Factors in Service Decision Making

Service delivery decisions by case coordinators are affected by a number of factors:

- Caseload Size;
- Service Worker Availability/Dependability;
- Client Needs;
- Client Complaints;
- Case Coordinator Skills; and,
- Needs of Professional Staff.

These factors can and do result in inappropriate service decisions, although it was not possible to quantify the degree of over servicing that results.

Each of the above factors and its impact on service delivery is outlined briefly below:

- **Caseload Size** affects the type of worker assigned by a case coordinator to a case. For example, if the case coordinator's caseload is high, and he/she feels unable to meet the program standard of reassessment every three months, the coordinator is likely to place a professional rather than a non-professional in the home if the client is at risk. This ensures that the client will be assessed by a professional and the case coordinator will be notified if and when client changes occur. In these situations, the following worker substitutions may occur:
    - RN rather than LPN; and,
    - LPN rather than HCA.

- **Service Worker Availability/Dependability**. Some regions may not be able to access all levels/groups of direct service workers because of a lack of appropriate workers or difficulty attracting them to the region. As a result, the most appropriate personnel are not always assigned to clients. Examples include:

    - RN providing services when only LPN skills are required because a LPN is not available;

    - Home Care Attendant providing homemaking services where a Home Support Worker is not available; and,

    - RN delivering care to a client in a community because the nearest LPN must travel a great distance.

  The dependability of the group of workers is also considered in making service delivery decisions. For example, the VON is perceived as highly dependable whereas orderlies are perceived as less dependable. If necessary, a rationale can always be found to justify employing a nurse rather than an orderly to perform personal care requirements of a frail elderly client.

- **Client Needs**. The intensity of client needs also is considered when direct service staff are assigned to individual cases. If one client requires a bath, medication set up and health teaching, an RN is likely to be assigned rather than each of a HCA, a LPN and a RN. Similarly, when a client requires both personal care and homemaking services only the HCA is assigned rather than sending both a HSW and a HCA to care for the client.

In both these case examples, some home care services were provided by persons with more than the minimum skill required to provide each service. Staff interviewed, however, believed this is the most cost effective manner of service delivery. Only one worker was being utilized rather than two or three workers, saving scheduling and travel time.

- **Client Complaints**. The handling of client and/or family complaints takes considerable skill and time on the part of the case coordinator. The majority of these complaints concern reduction in services. The time involved in dealing with client complaint phone calls and associated follow-up often is weighed against the cost of providing a higher level service worker. Frequently, a case coordinator will place the higher level service worker (e.g., RN/LPN rather than HCA) to reduce the time spent by the case coordinator in dealing with complaints. The rationale for this decision may also include the client's need for education or professional observation. The following example demonstrates this situation:

> Mrs. J. received a weekly bath from a LPN for approximately one year. Upon reassessment it was decided that a HCA was the most appropriate worker to provide the bath. When the HCA was assigned to the case, the client and/or her family contacted the case coordinator daily until the case coordinator reinstated the LPN. The justification used to reassign the LPN to the case was the need to teach the client independence in personal care.

The need to provide case coordinators with conflict resolution skills has been identified in many regions. Action is currently being taken to develop training sessions and workshops in this area.

Case Coordinator Skills. The skills and professional background of case coordinators affects decisions made about the appropriate staff to provide services. Specifically, a case coordinator who is a social worker not yet familiar with medical jargon may be more likely to assign professional nursing staff to their clients with medical/nursing needs. A social worker may also be less likely to challenge the initial and ongoing assessments performed by direct nursing staff. For this reason it is not uncommon to find social worker case coordinators using direct nursing staff in situations where a less skilled worker is appropriate.

The team approach (i.e., a nurse and social worker) to case coordination can help to alleviate the uncertainty of social workers in these situations. By ensuring adequate access to the nursing care coordinator, the social worker is able to seek appropriate consultation.

While not wanting to recommend one type of case coordinator professional for Manitoba's Continuing Care Program, there are data to suggest that nurses are more suited to the position of case coordinator than social workers. Both management and case coordinators themselves reported on the difficulties encountered by social worker case coordinators in initially dealing with complex medical cases or the functional implications of medical conditions. In fact, from the review of client files, there are very few clients who do not have at least one medical problem affecting their functional status.

The educational preparation of nurses provides them with a broader understanding of functional status and the impact of disease on activities of daily living. This is not to say that social workers and other professionals do not make important or valuable contributions to the Program. Rather, in some districts of the province where only one case coordinator is needed, the nursing professional should be given strong preference.

- **Needs of Professional Staff**. In order to qualify for the annual renewal of registration in the Province of Manitoba without taking a continuing education course, registered nurses must have:

> "practiced as a registered nurse for a total of at least sixty working days in the three year period immediately preceding the registration year of the Association for which a renewal of registration is sought."

Although not a common practice, some direct service worker RNs are assigned to cases that might otherwise be assigned to LPNs or HCAs to meet their renewal requirements.

In conducting client file reviews across the province, it is the consultant's opinion that case coordinators generally assigned the appropriate level of direct service worker. There were cases, though, where client care needs could have been handled by a worker less skilled than the one assigned to the case (e.g., LPN rather than RN and HCA rather than LPN/RN). Data from the client survey tend to support this statement. As for the frequency of visits, the consultants agreed that they too were generally appropriate and based on client need.

OPTIONS

Clearly, caseload review is an important powerful tool to monitor service delivery decisions by case coordinators. A second, somewhat less obvious monitoring tool, is case coordinator supervision. Program supervisors could participate in the case reviews or reassessments conducted by case coordinators and assist them with difficult service delivery decisions.

Another option to ensuring appropriate selection of direct service workers is to ensure the detailed admission assessment form is complete and accurate. The assessment leads the case coordinator to the identification of care needs and the development of a care plan. In Toronto, by contrast, Home Care Case Managers actually list the service goals on the assessment form. The goals stated reflect the goals of the program, for example:

> "To assist the client with medical treatment by
> 1. ________________________________
> 2. ________________________________
> 3. ________________________________
> 4. ________________________________
> 5. ________________________________."

While this method is not superior to the care plan method utilized by the Manitoba Program, its effectiveness as a tool for service decisions is increased through the use of standards for charting and regular chart audits. Thus, all case managers consistently use one format and, theoretically, one set of assessment factors to arrive at service decisions. The Continuing Care Program should consider developing comprehensive charting standards for their assessment tool as well as a consistent and frequently utilized monitoring process to ensure its use.

Clients Unaware of Appeal Process

An appeal process helps to:

- identify unmet client needs;
- provide important feedback for quality control and policy development; and,
- identify Program issues before they are brought before the press or pursued at political levels.

Fifty-seven percent of the clients surveyed did not know how to appeal service delivery decisions. Of those who stated they were aware of the appeal process:

42% would contact the social worker coordinator;
24% would contact the nurse coordinator;
18% would contact other non-program staff; and,
16% would contact other program staff

to appeal the decisions of program staff or lodge a complaint.

If clients are unaware of the appeal process, service problems may not be addressed. It is also possible that ministerial enquiries may be perceived by some as the only method of appeal available. Furthermore, if clients are unhappy with the Continuing Care Program and lack information regarding channels to pursue change, home care may be perceived negatively.

The distribution to clients and their physicians of a written pamphlet outlining the appeal process would ensure that clients follow appropriate investigative channels. Having clients sign a contract form indicating their understanding of and commitment to use the appeal process will not only ensure that the process is taken seriously, but will also ensure that clients become active members in their care plan. A second, somewhat less costly option, is to ensure verbal appeal instructions are provided to clients at admission and at reassessment times.

Actual provincial data on client complaints is not easy to capture. Not all complaints find their way to the Office of Continuing Care; they are generally handled at the regional level. Also not all ministerial enquiries directed to the Office of Continuing Care are complaints. Without a central registry of complaints or appeals, analysis of the frequency and/or type of complaint is not impossible but very time consuming. Our consultants reported that the example of client complaint cited most frequently by regional staff was reduction in homemaking services. This is not surprising considering 42% of the clients surveyed reported homemaking services as the most valued service.

Case Coordinator Role in Direct Service Work

In the Generic provincial job description, case coordinators are expected to provide, where appropriate, professional intervention through "counselling, teaching, guidance, crisis intervention, referral, etc." This "hands on" direct service work by case coordinators detracts from actual case coordination - especially reassessments. In reality, the high regional caseloads prohibit "hands on" work by case coordinators, even though many are concerned about keeping up their professional skills.

Case Coordinators also become frustrated when clients in their care require counselling and/or teaching and they are unable to meet the demand. While a nursing service such as health teaching can be purchased from direct nursing staffing, direct social work staff is not available on a service purchase basis. Social counselling in the rural regions is only available when social worker case coordinators provide "hands on" care.

Two options are suggested for consideration. First, removing the expectation that case coordinators must provide "hands on" client care will free them to concentrate on case coordination including conducting timely reassessments. Adequate numbers of direct service workers (nursing and social work), however, must be available to meet client needs in the areas of teaching and counselling. In several areas of Ontario, local home care administering agencies have hired a social worker to provide social counselling for clients as well as consultation for Program staff.

A second option is to reduce caseload size in order to allow case coordinators to provide the necessary client counselling and teaching services in the region, especially for social worker case coordinators. This option would allow professional staff to maintain their assessment skills and their professional identity.

In comparison, Home Care Case Managers in Ontario do not provide "hands on" care, nor do they counsel or teach clients; direct nursing and social worker service workers provide this service. They are, however, concerned about maintaining their professional skills. Some case managers actually take on occasional part time work in their fields to maintain their skills. Ontario Home care administrators, in contrast to case managers, believe that full time attention to case coordination reduces the potential role conflict associated with case management (service delivery) and care giver roles.

Clearly, given the potential for role conflict, the preferred option is to remove the expectation that case coordinators provide direct service provision.

Exhibit 25, at the end of this chapter, summarizes the findings, implications, and options/solutions regarding service delivery.

Exhibit 25

SUMMARY FINDINGS: SERVICE DELIVERY

ISSUES/CONCERNS	IMPLICATIONS	OPTIONS/SOLUTIONS
1. Regional organizational structure variations . some regional continuing care coordinators have competing responsibilities . some CCP staff report to non CCP supervisors . some regions lack the resources development function	. inconsistent and at times inadequate program management . undermines commitment to program management . some supervision lacks program content . program staff lack direction on program issues . deficient control of resource coordination function . short comings in identifying and establishing service resource options	. ensure minimal organizational requirements . full time regional continuing care coordinator . CCP staff report to CCP supervisors . required resource development functions
2. Some regions lack program supervisors	. performance appraisals not done . lack of supervision . lack of case load reviews . failure to solve caseload problems in a timely fashion	. ensure adequate number of program supervisors
3. Case coordinators consider different sets of factors in service decision making	. inconsistent servicing . inappropriate service providers . unsafe client situations	. use caseload review to monitor service decisions . increase case coordinator supervision . develop and utilize charting standards for assessments . implement chart audits
4. Some clients unaware of appeal process	. client service problems not addressed . ministerial enquiries . negative perception of home care	. written pamphlet and client signature and/or . verbal instructions at admission and reassessments
5. Case coordinator role in direct service work	. less time for coordination . questionable service skills . frustration	. prohibit "hands on" work by case coordinators, and ensure sufficient number of direct service worker, or . reduce caseloads to allow direct service work by coordinators

SERVICE DELIVERY: RECOMMENDATIONS

1. THE PROGRAM SHOULD ESTABLISH MINIMAL ORGANIZATIONAL REQUIREMENTS:

   - THE REGIONAL CONTINUING CARE COORDINATOR POSITIONS SHOULD BE FULL-TIME AND INDIVIDUALS HOLDING THESE POSITIONS SHOULD NOT BE GIVEN OTHER SIGNIFICANT RESPONSIBILITIES SUCH AS AREA MANAGEMENT ROLES;

   - IN REGIONAL ORGANIZATIONAL STRUCTURES, CONTINUING CARE PROGRAM STAFF SHOULD REPORT TO SUPERVISORS IN THE CONTINUING CARE PROGRAM; AND

   - EACH REGION SHOULD BE RESPONSIBLE FOR ASSIGNING RESOURCE DEVELOPMENT RESPONSIBILITIES TO APPROPRIATE PROGRAM STAFF.

   COMPLIANCE WITH THESE ORGANIZATIONAL REQUIREMENTS SHOULD BE MONITORED THROUGH THE PROGRAM REVIEW PROCESS.

2. STAFF SHOULD BE APPOINTED IN EACH REGION TO SUPERVISE CASE COORDINATORS. THESE RESPONSIBILITIES SHOULD NOT BE GIVEN TO THE REGIONAL CONTINUING CARE COORDINATOR. THERE SHOULD BE AT LEAST ONE SUPERVISOR FOR EVERY EIGHT CASE COORDINATORS. IN SOME REGIONS, THIS WILL REQUIRE ADDITIONAL STAFFING RESOURCES.

3. CASELOAD REVIEW SHOULD BE USED TO MONITOR CASE COORDINATOR SERVICE DELIVERY DECISIONS AND ANY SHORTCOMINGS IN SUPERVISION. FURTHER, ASSESSMENT CHARTING STANDARDS SHOULD BE DEVELOPED AND ASSESSMENT CHART AUDITS REGULARLY INCORPORATED IN THE CASELOAD REVIEW PROCESS.

4. A WRITTEN PAMPHLET OUTLINING THE CLIENT APPEAL PROCESS SHOULD BE PREPARED. IT SHOULD BE MADE AVAILABLE TO PROGRAM STAFF AND DISTRIBUTED TO ALL CLIENTS ON ADMISSION. CLIENTS SHOULD SIGN A FORM INDICATING AWARENESS OF THE PROCESS. AT THE TIME OF REASSESSMENT OR AT SERVICE CHANGE, CLIENTS SHOULD BE ADVISED AGAIN OF THE APPEAL PROCESS. THE OFFICE OF CONTINUING CARE SHOULD ESTABLISH A MECHANISM TO MONITOR CLIENT AWARENESS OF APPEAL PROCEDURES. THIS COULD ENTAIL AN ANNUAL AUDIT INVOLVING TELEPHONE INTERVIEWS WITH A SMALL SAMPLE OF CLIENTS.

5. THE OFFICE OF CONTINUING CARE SHOULD ELIMINATE THE RESPONSIBILITIES FOR CASE COORDINATORS REGARDING PROVISION OF DIRECT SERVICE (E.G., COUNSELLING/TEACHING). THE RESULTS OF THIS CHANGE SHOULD BE TAKEN INTO ACCOUNT IN IDENTIFYING STAFF YEAR REQUIREMENTS.

16. INTAKE/ASSESSMENT/PANELLING

BACKGROUND

The review looked at the various assessment and case management practices with a view to assessing their effectiveness and uniformity. In this chapter, three major operational activities are discussed: Intake, Assessment and Panelling. The findings are summarized in an Exhibit at the end of the chapter.

Prior to discussing the intake process of the Program, it is worth noting that access to the Continuing Care Program is direct for clients and their families. The Kanes stated that the "elimination of a requirement for professional referral ... is an important aspect" of the Program. Our consultants agreed with the Kanes, noting that in Ontario clients must be under medical supervision and require at least one professional service (e.g., nursing, physiotherapy, occupational therapy and so on) to be eligible for home care services.

Direct access by clients is noteworthy for two reasons. First, as outlined by the Kanes:

> "...in too many situations professionals who should know about community services are ill-informed and sometimes even indifferent."

Second, direct access prevents the potential misuse of professional services to provide the necessary homemaking services for elderly clients (as is sometimes suspect in the Ontario program).

INTAKE

Description

Referrals to the Continuing Care Program come from a variety of sources:

- clients;
- family/friends;
- physicians;
- hospitals;
- own agency (Continuing Care Program); and,
- other agencies.

Intake is the mechanism of first contact with the Departments of Health and Community Services and occurs only at the regional level. It has both a public relations as well as a liaison function. The main purpose is to assess the client problem and appropriately refer the client to the necessary resource. This means that in addition to assessment skills, the intake worker must possess knowledge of:

- health and community services;
- admission eligibility for programs; and,
- community resources available.

The majority of regional intake workers for continuing care are professionals. In fact, many regions assign case coordinators as intake workers on a rotating basis. That is, on specifically assigned days case coordinators are expected to act as the intake worker for home care. This process differs somewhat in Winnipeg as regional intake workers are assigned permanently due to the volume of service referrals.

Even though professionals are staffing home care intake, almost all referrals are assessed "in person". Generally, little assessment or screening is conducted over the phone.

Based on the 1980-1986 referral statistics (Table 4), only a small percentage (22-42%) of home care referrals are phone calls (i.e., self, family/friend and/or doctor referrals). The bulk of referrals (58-78%) are written requests for service where adequate client information is available on a form to determine appropriate resource referral (i.e., hospital, agency and/or doctor referrals).

Findings

There are inefficiencies within the intake process as it exists in some regions. Specifically, there is a lack of screening for program eligibility on intake resulting in an unnecessarily high number of in-person intake assessments. Case coordinators assigned intake duties merely solicit basic client information on the phone and arrange to conduct an in-person assessment of client needs. Between 1980 and 1986, 54%-82% of the individuals who were assessed for the Program were not admitted because a) home care was not required; or b) the patient/family refused care. (Table 5). These proportions (i.e., 54% - 82%) suggest that significant savings could be achieved if eligibility screening was conducted on intake.

Appropriate active intake screening could be used to eliminate in person visits for ineligible clients and client/family refusals and orient potential clients to program services, eligibility criteria and the appeal process.

A second factor indicating an inefficient intake process is the duplication of data collected during intake and initial in person assessments. In some regions, case coordinators collect enough client data over the phone to determine the most appropriate match between client needs and case coordinator skills (nursing or social work). The most appropriate case coordinator is then scheduled to visit the client

Table 4

SOURCE OF REFERRAL FOR THOSE ADMITTED TO HOME CARE

DECEMBER 1980 - 1986

Referral Source/Year	1980	1981	1982	1983	1984	1985	1986
Self	6%	10%	8%	6%	7%	7%	5%
Doctor	23%	22%	17%	24%	21%	20%	16%
Hospital	46%	47%	49%	47%	50%	49%	55%
Family/Friend	18%	13%	17%	13%	13%	14%	14%
Other Agency	4%	5%	5%	7%	5%	7%	7%
Own Agency	3%	3%	4%	3%	4%	3%	3%
Total	100%	100%	100%	100%	100%	100%	100%
	n=705	n=792	n=790	n=765	n=785	n=970	n=941

Table 5

REASONS FOR NOT ADMITTING PERSONS ASSESSED BUT NOT ADMITTED TO HOME CARE

DECEMBER 1980 - 1986

Reason/Year	1980	1981	1982	1983	1984	1985	1986
HC not required	73%	43%	65%	61%	60%	59%	59%
Pt/family refused	9%	11%	7%	7%	12%	15%	15%
Admitted to facility	7%	11%	6%	11%	8%	6%	8%
Home not suitable	1%	1%	1%	2%	1%	1%	2%
Person deceased	1%	7%	1%	0%	4%	1%	1%
Other	9%	28%	20%	19%	15%	19%	15%
Total	100%	100%	100%	100%	100%	100%	100%
	n=71	n=122	n=97	n=141	n=119	n=165	n=169

in person. The nurse or social worker case coordinator assigned to the case then collects similar information when assessing the client at home. Not only is this repetitive process time consuming for the client, it has time and cost implications for the Continuing Care Program.

Options

There are two options that should be considered in addressing the inefficiencies of the intake process.

. First, active screening could be introduced by professional intake workers (e.g., case coordinators or social worker or a nurse). By conducting client mini-assessments over the phone, program eligibility can be determined for a number of clients being referred. This reduces the number of costly in person assessments necessary. In fact, Winnipeg North demonstrated that in the absence of professional screening, a 110% increase was noted for in person intake assessments. Furthermore, sixty percent of those assessed were never admitted to the program.

The benefits of using a professional intake worker to handle incoming phone referrals include:

- appropriate use of case coordinators;
- prioritization of incoming clients;
- reduced case coordinator time spent on service orientation during the assessment process; and,
- reduction of assessments that do not result in admissions.

. A second alternative is to continue current practices but train support personnel to gather basic client information for phone referrals using the standard provincial intake form. This would be especially effective if only a small percentage of referrals are telephone referrals. The documented referrals from agencies and professionals could be transferred directly to the case coordinators. Use of support staff in this situation not only frees case coordinators from intake, it consumes less financial resources.

ASSESSMENT

Description

Service delivery in Manitoba is based on a comprehensive assessment of client need: clinical, health and social. Exhibit 26, following, depicts the assessment process. The process is enhanced by a standard provincial multidimensional assessment instrument (Appendix R) capturing client information relative to the following areas:

- family;
- household;
- health;
- personal care; and,
- psycho/social needs.

In addition, the summary assessment page of the instrument identifies client needs in each area and includes equipment and supply needs. Client needs, provide the impetus for the care plan which is designed to set out the services necessary to meet client need.

Exhibit 27, following, shows the locus of responsibility for providing the minimum care to meet needs and to foster client independence. As shown in the figure, Home Care eligibility is attained only when other health and social service programs, volunteers, non-profit services and friends and neighbors services have been exhausted. Home Care services, (nursing, personal care, household safety and maintenance, respite and adult day program) are then put into place. Eligibility for facility or long term institutional care is established when all community and home

Exhibit 26

Continuing Care Assessment Process *

ASSESSMENT

I. CLINICAL STATUS

A. COLLECT

1. Hospital Reference - Clinical Data provided on Discharge Form
2. Community Reference -
   - a) From Doctor
     - Letter
     - B.I.F. Form
     - Pers. Care Home Applic. Assess.
     - Verbal - Phone
   - b) Others
     - Write to Doctor
     - Phone Family Doctor
     - Arrange for Medical Assess. Family Doctor Geriatric Assess.

B. ANALYSE

What does this medical data mean in terms of ability to function?

II. HEALTH FUNCTIONING

A. COLLECT SUBJECTIVE AND OBJECTIVE DATA RE: CLIENT

- nursing or health history
- reason for contact
- biographical data

AND INCLUDES:

- a) body systems review (includes physical assessment)
- b) current health status
- c) past health history
- d) family health history
- e) social history (includes environment

B. ANALYSE

What does this health functioning data mean in terms of ability to function?

III. SOCIAL FUNCTIONING

A. COLLECT DATA ON:

- a) family
- b) other relationships
  - inter
  - intra
  - community
- c) values
- d) roles - perception/changes
- e) behaviour (patterns)
- f) culture
- g) psychological status
  - emotional
  - mental
- h) economic (financial) status
- i) social activities

B. ANALYSE

What does this social functioning data means in terms of ability to function?

* Home Care Review 1985

RESPONSIBILITY FOR CARE CONTINUUM *

PERSON ←-------→ FAMILY & COMMUNITY ←---|---→ HOME CARE ←---|---→ LONG TERM INSTITUTION

FAMILY:
- -Household
- -Near by Family

COMMUNITY:
- -Other Health & Social Service Programs
- -Volunteers
- -Non Profit Services
- -Friends & Neighbours

ELIGIBILITY

ELIGIBILITY

CONTINUING CARE SERVICES

- -Assessment
  - -Clients' Abilities
  - -Availability of other resources
- -Determination of eligibility for Home Care Services
- -Care Planning
  - -goal directed and time framed
- -Reassessment
- Development of Community Resources that Foster Independent Living

HOME CARE SERVICES

- -Nursing Care
- -Personel Care and Hygiene
- -Household Safety and Maintenance
- -Respite
- -Adult Day Program

-Determination of Eligibility for Insured Nursing Home Services

Exhibit 27

* Developed by Westman Region

care resources are exhausted and client needs continue to place them at risk within the community. This figure and the vertical dotted lines demonstrate the intake, and assessment points along the continuum of care within the Program.

In this section, the assessment conducted to determine home care eligibility is discussed. One or both of the professional nursing or social work staff is used to perform the assessment. In most cases, the first assessment is likely to be by the nurse who, on the basis of her observations and professional judgment, determines the need for a second social assessment. In those instances when the first assessment is by the social worker, the basic procedure is the same. The Continuing Care guidelines require a total assessment (clinical status, health functioning, social functioning and environmental support) of the client's ability to function in the home environment.

Published academic literature on the Manitoba Continuing Care Program often makes reference to the joint social worker-nursing assessment as a key feature of the program. However, nowhere in program documents is it specified that interdisciplinary/joint team assessments (registered nurse and social worker) are required.

The three Winnipeg regions are the only regions regularly conducting inter-disciplinary assessments. The rural regions use the consultative model, seeking out the knowledge and skills of the complementary professionals when required. VON in the delivery of short term care, use nursing professionals only - although social worker consults are available for those clients in hospital.

Once the assessment process is complete, the care plan is implemented and services are put into place through a referral process. While the actual process differs somewhat across the province, depending on the service requested, there are several steps that are to be followed when services outside the direct service worker area (HCA, HSW, LPN, RN) are ordered. Using a referral to occupational and/or physiotherapy services as an example, the steps in the referral process are as follows:

- the case coordinator completes a provincial form for occupational or physiotherapy services. This form contains information relating to client demographics, diagnosis, other health conditions, clinical history, activities of daily living capabilities, and, physician and/or hospital information. Information is also provided regarding the type of service being requested, the home care services currently in place, the referring home care office and case coordinator, and, any other pertinent information deemed appropriate by the referring person;

- the referral form is forwarded to the therapy services offices with a copy retained for the client file;

- a therapist visits the client, assesses their need for therapy and implements a specific plan of care based on the assessment findings;

- a copy of the therapy assessment findings is forwarded to the appropriate home care office and appended to the client file; and,

- the therapy plan of care (i.e.. visit frequency) is recorded on the service plan by the case coordinator.

Findings

The Kanes, in their report, suggest that there is a "reasonable basis for assuming that the initial assessments are generally well done". Our consultants agreed with the Kanes' statement, having attended initial assessments in three regions. The standard multi-dimensional assessment tool assisted case coordinators in conducting a detailed assessment. This standard provincial tool is envied by many and held up as a model (albeit a lengthy tool) in Ontario where the Ontario Home Care Program does not utilize a standard provincial assessment.

Our review, however, noted two major concerns about the assessment process:

- the indiscriminate use of joint assessments in Winnipeg; and,
- the lack of availability of social worker input for multi-dimensional assessments in some regions.

Indiscriminate Use of Joint Assessments

The indiscriminate use of joint assessments in Winnipeg is a concern because of the estimated savings of two to four staff years which could be realized if single discipline assessments were conducted (Home Care Review, 1985). A few program staff, usually individuals with a social work background, argue that the joint assessments contribute to the following:

- better and more cost-effective care plans;
- early identification of problems that could prevent client/family crises; and,
- reassurance of clients that all his/her needs are being addressed.

However, our review found no concrete data to support these arguments. It is important that multi-disciplinary assessments are not equated with multi-disciplinary assessment teams. Theoretically, one could argue that both disciplines are necessary for the unique contributions they make to a comprehensive assessment i.e., nursing for its clinical and health expertise and social work for its skill in the psycho/social area. This assumes, however, that neither profession is capable of conducting a comprehensive assessment on their own. Realistically, given the detailed assessment instrument and the professional qualifications of staff who gather client data, either profession is capable of a comprehensive assessment of the client's ability to function in the home environment. Since the program guidelines do not suggest physical assessments are necessary, social workers are capable of collecting the health information requested.

Field staff conducting joint assessments expressed concerns that these assessments are time consuming, threatening for the client, not necessary for all cases, and redundant. In addition, case coordinators believed joint assessments required good interviewing and team work skills not always well developed in case coordinators.

Nonetheless, individuals conducting joint assessments were strong advocates for this method when assessor skills/experience were not sufficient to identify client needs, or when client cases were complex, or when a second professional opinion was required.

There are client cases that would benefit from a joint assessment on intake, especially in the Winnipeg region where complex medical and social cases are not uncommon. In these cases, time and cost savings could be realized by conducting one joint assessment rather than two separate assessments. What is missing is the ability of case coordinators to identify, in advance, those cases that would benefit from such an assessment.

Lack of Social Worker Availability

A second concern, somewhat related to joint assessments but also clearly related to staffing, is that not all regions have equal access to social worker case coordinators. In fact, one region was completely staffed by nursing case coordinators. Other rural regions have only one social worker case coordinator. As a result, joint assessments even when necessary or desired, are a luxury or even impossible to attain.

This lack of social worker input was cause for concern for many continuing care staff. Nursing access to the complementary social professional is essential to prevent erosion of long term care such as social care as well as to continue to provide a multi-dimensional approach to care and to ensure comprehensive assessments are conducted. The Kanes also noted that a multi-disciplinary mix of case coordinators would help to ensure that the "program itself is enriched by multiple perspectives".

Two suggestions are put forward to address joint (nursing and social work) assessments. First, indiscriminate use of joint assessments should be eliminated. A second professional should be consulted only in specific and unusual circumstances. Mechanisms to monitor the frequency and appropriateness of consults should be put into effect to ensure compliance with the above and to establish the type of client situations requiring a second professional consult.

Second, there must be improved access to social workers in rural regions, functioning in a consultative role to nursing case coordinators. In several agencies administering Home Care in Ontario, a social worker is employed to provide the necessary counselling for clients and consultations for case coordinators. He or she does not function as a case coordinator but rather as a direct service worker and regional program consultant for social work. Regions with a high percentage of widowed clients (Norman, Parklands), palliative cases (Interlake) and complex social cases (Winnipeg) might consider this approach to ensuring adequate access to social workers.

PANELLING

Description

Clients no longer able to continue in the community without mental, social or health care risk are assessed for appropriate care in a setting that provides ongoing support and/or treatment care on a 24 hours basis. The MHSC is responsible for:

- . the payment of cost of care;
- . program and standards of care within the facility; and,
- . criteria for assessment of care in a personal care home.

The Continuing Care Program is responsible for:

- . assessing client need and application for Personal Care Home care;
- . establishing panels in Manitoba;
- . establishing prioritization for placement; and,
- . maintaining waiting lists.

The Regional Continuing Care Coordinators are responsible for:

- . ensuring assessments are completed;
- . panel operations; and,
- . appropriate waiting list management including bed holding authorizations.

The Case Coordinators are responsible for:

- . presenting the client case to panel;

- working with client/family through panel process; and,
- conducting placement reassessments every 6 months.

The assessment includes a clinical, health functioning and social functioning assessment and is recorded on a standard MHSC provincial application/assessment form.

The assessment panel is a group of health professionals responsible for assessing the needs of clients for personal care home placement. The panel usually includes a Regional Continuing Care Coordinator or designate, a registered nurse, a social worker and a medical doctor. It is normally held within the client's residential area and may include Personal Care Home Representatives.

The panel is responsible for:

- establishing need for personal care home placement;
- assessing client level of care needs;
- determining priority of placement need; and,
- reassessing clients who may no longer require placement.

Criteria established by MHSC are used for level of care determination and priority placements. Waiting list and priority definitions and procedures are outlined clearly in the Continuing Care Program Manual.

The policy procedures for inter-regional placement, bed holding, client signatures, and special care need client placement also are clearly outlined in the manual.

Findings

Prior to discussing our findings regarding the panelling process in Manitoba, it is worth noting that the Kanes' report cited the panelling procedure as a "commendable feature of the Manitoba Program" because it "provides a useful structure for oversight of case coordinators' decisions and permits a fuller medical assessment before major relocations" of clients. Our review also concluded that the process of panelling can prevent hasty decisions to enter personal care homes, decisions based on insufficient knowledge of community resources or client needs.

The Kanes also stated that the panel process can become "perfunctory" if not watched closely and it does not substitute for an evaluation of the accuracy of case coordinators' decisions." Our review team did not witness perfunctory panel processes; rather, they witnessed inconsistencies that could ultimately lead to the erosion of the panel process.

Based on our review findings there are three major concerns with the panelling function that will be discussed briefly below:

- inconsistent panel membership;
- inconsistent panel format; and,
- inappropriate use of the panel process.

Inconsistent Panel Membership

Panel membership differs across regions. Table 6 identifies the usual panel participants. Although the standard provincial assessment/ application form is completed before the panel sits, members of the panel have a final opportunity to probe, challenge, discuss, debate, and question the assessment findings presented before them. If, for example, there is no medical representation on panel, the medical component of the application is accepted at face value. Similarly, the lack of social and/or nursing representation has the same effect; the respective assessments are unchallenged. Consequently, consistent panel decisions across regions given inconsistent panel membership is questionable.

Table 6

1987 PANEL MEMBERSHIP IN PROVINCIAL REGIONS

Region/Panel	RCCC	RN Supervisor	SW Supervisor	M.D.	Hospital Rep.	PCH Rep.	Regional Director	Treaty Rep.
Norman	*		*					
Thompson	*			*			*	*
Eastman	*		*	*				
Westman	*	*	*					
Central	*	*		*	*	*		
Interlake	*			*				
Parklands		*	*	*				
Winnipeg S.			*	*				
Winnipeg N.			*	*				
Winnipeg W.C.			*	*				

Although the lack of consistent multi-disciplinary representation in itself may not be a problem, it emphasizes the validity of the written assessment. Furthermore, if the documented assessment is to be unchallenged, the panel meeting may make no contribution and the panel process can become perfunctory.

Inconsistent Panel Format

Having attended panels in three regions, our consultants noted inconsistencies across panels in the formats followed, which raised concerns about the fairness of panel decisions. Without a format or checklist of questions, there is no assurance that all panel cases are treated equitably, and that all issues are discussed or resource avenues explored.

Further, panelling involves numerous individuals, all of whom spend time travelling to and participating in the panel. An approximate cost to hold one panel review session of 10 clients in a two hour period was calculated to be $202.47 (Table 7). This figure does not include travel time, client preparation time, physician time or the cost of materials. As a result, inadequate case preparation and presentation can be costly.

There are factors arising from inadequate case preparation and presentation that serve to increase further the costs of panel:

- applications being read for the first time at panel;
- case coordinators presenting client findings and not always including pertinent facts and findings;
- incomplete application forms;
- inappropriate panel cases being presented (identified as inappropriate by case coordinators themselves);
- no time frame established per case resulting in lengthy and involved discussions; and,

Table 7

APPROXIMATE COST TO HOLD ONE PANEL REVIEW

Participant	Median Salary (Hour)	Panel Preparation (Hour)	Panel Participation (Hour)	Panel Follow-up (Hour)
Regional Continuing Care Coordinators	$19.53	0.5	2.0	1.0
RN Supervisor	18.45	0.5	2.0	-
SW Supervisor	18.45	0.5	2.0	-
Case Coordinator	14.32	2.5	2.0	1.0

Total Cost: $202.47

. case coordinators travelling great distances and sitting through total panel meeting (as long as five hours).

Furthermore, there are data to suggest that 15-18% of all cases brought to panel are not appropriate (Table 8). Either placement is not required (home care services are appropriate) or the case is deferred until a later date. Deferrals occur for various reasons, two of which are: poor planning (i.e., incomplete information available for panel decision) and poor scheduling (i.e., not enough time to hear client case). Deferrals can also allow time for further assessments or exploration of available community resources.

While the consultants recognized that panel is often utilized for consultation and assistance in planning for care at home in complex situations, it is suggested that a case/team conference would be a more appropriate method for case consultation. Telephone conferences could be utilized to accomplish similar objectives at a reduced cost (less travel, less paperwork, less time).

Inappropriate Use of Panel Process

The following two examples demonstrate inappropriate and/or misuse of the panel process witnessed by our consultants.

The panel process can be used to enrich client services beyond the cost limit established for alternative care. This is achieved by a positive panel recommendation for client placement into a personal care home. Once attained, care that costs more than alternative care options is approved for the period during which the client waits for an opening in the Personal Care Home of their choice. The panel process also can be used to move difficult to care for or heavy care clients into personal care homes even though home care is more appropriate. Through the manipulation of the client's level of care to a level that warrants

Table 8

PANEL DECISIONS FOR NEW PERSONS ASSESSED FOR PERSONAL CARE HOME PLACEMENT

DECEMBER 1980 - 1986

Panel Decision/Year	1981	1982	1983	1984	1985	1986
PCH placement	85%	83%	84%	82%	85%	84%
Hospital/extended care	-	3%	2%	-	-	-
Home Care only	3%	1%	4%	4%	2%	2%
HC placement not required	1%	2%	2%	-	2%	3%
Deferred	7%	9%	7%	11%	11%	8%
Other	3%	2%	1%	3%	-	3%
Total	100%	100%	100%	100%	100%	100%
	n=251	n=188	n=216	n=182	n=210	n=180

PERCENTAGE OF CLIENTS PANELLED THAT ARE RECOMMENDED/NOT RECOMMENDED FOR PCH PLACEMENT

DECEMBER 1980 - 1986

Panel Decision/Year	1981	1982	1983	1984	1985	1986
Placement recommended	85%	83%	84%	82%	85%	84%
Placement not recommended	15%	17%	16%	18%	15%	16%
Total	100%	100%	100%	100%	100%	100%
	n=251	n=188	n=216	n=182	n=210	n=180

placement, clients can be inappropriately placed. The Kanes also make reference to the fact that incentives do exist for case coordinators to refer difficult clients to personal care homes.

Options

To address concerns dealing with the panelling process, the following are suggested for consideration:

- consistent panel membership across regions that include medical, nursing and social work representation. Not only are clients assured of consistent panel members, each case is reviewed by a truly multi-disciplinary team. Although a geriatrician would be an ideal panel member, we realize that this is not a realistic option given the difficulty recruiting to the Northern and remote regions;
- development and implementation of panel guidelines/format to ensure a consistent approach to panel decision making across the province;
- develop guidelines for panel case preparation and presentation to be utilized by case coordinators both in presenting the case in writing and verbally at panel;
- conduct on site panel review process (similar to the caseload review process) by the Office of Continuing Care to ensure consistency of panel membership and panel process, as well as appropriate panel functioning;
- audit panel documentation (i.e., assessment forms and client files) to ensure appropriate use of panel process. This function should be performed by the Office of Continuing Care staff on a regular basis throughout the province.

The findings on intake, assessment and panelling are summarized in Exhibit 28, following.

Exhibit 28

SUMMARY FINDINGS : INTAKE/ASSESSMENT/PANELLING

ISSUES/CONCERNS	IMPLICATIONS	OPTIONS
1. Inefficient intake process . lack of screening . duplication of data collection (intake and assessment)	. unnecessarily high number of on site assessments . time and other cost implications	. introduce pre-assessment screening . alternatively, intake information could be collected by support staff
2. Indiscriminate use of joint assessments in Winnipeg (nurse and social worker)	. estimated cost of 2-4 staff years . may overwhelm client	. analysis to investigate in what instances joint assessments are cost effective . use second professional in consultative role
3. Inconsistent panel membership	. inconsistency of panel decisions . concerns about fairness of decision making	. consistent membership across regions . panel guidelines/format development and implementation
4. Inconsistent panel format	. time and other cost implications . inadequate case preparation and presentation . inappropriate panel cases . incomplete applications . lacks thorough case presentation	. develop guidelines for cases presentation - written and oral . on site panel review by OCC
5. Inappropriate use of panel process	. clients panelled to enrich services rather than for care needs . manipulation of client's level of care to achieve panel placement	. audit of panel documentation by OCC . on site panel review by OCC

INTAKE/ASSESSMENT/PANELLING: RECOMMENDATIONS

1. PRE-ASSESSMENT SCREENING SHOULD BE INTRODUCED IN ALL REGIONS. THIS SCREENING SHOULD BE PERFORMED BY PROFESSIONAL STAFF. THE PROGRAM SHOULD ALSO DEVELOP A MECHANISM TO FLAG SELECTED CASES WHO ARE SCREENED OUT FROM ASSESSMENT. THESE CASES WOULD BE FOLLOWED UP TO ENSURE THEIR NEEDS HAVE BEEN MET.

2. THE OFFICE OF CONTINUING CARE SHOULD TERMINATE THE JOINT (SOCIAL WORKER AND NURSE) ASSESSMENT PROCESS AND SHOULD DEVELOP CRITERIA TO IDENTIFY INSTANCES WHERE A CONSULTATION FROM A CASE COORDINATOR OF ANOTHER DISCIPLINE IS INDICATED.

3. THE PROGRAM SHOULD IDENTIFY PANEL MEMBERSHIP REQUIREMENTS. THESE SHOULD BE APPLIED CONSISTENTLY ACROSS ALL REGIONS.

4. FURTHER GUIDELINES SHOULD BE DEVELOPED REGARDING REQUIRED FORMATS FOR CASE PREPARATION AND PANEL PRESENTATIONS. SUCH GUIDELINES WOULD SPECIFY REQUIRED CONTENT IN PREPARED CASE MATERIAL AND AREAS TO BE COVERED IN PANEL PRESENTATIONS.

5. THE OFFICE OF CONTINUING CARE SHOULD DEVELOP MECHANISMS TO MONITOR THE APPROPRIATE USE OF THE PANEL PROCESS INCLUDING A DOCUMENTATION AUDIT OF PREPARED CASE MATERIAL AND PANEL DECISIONS AND AN ON-SITE PANEL REVIEW PROCESS BY OFFICE OF CONTINUING CARE STAFF. (THIS PROCESS WOULD PARALLEL THE CASELOAD REVIEW PROCESS.)

17. STAFF WORKLOADS

BACKGROUND

The Review examined staff workloads, factors contributing to the current workload situation, and assessed the implications of current workloads.

DESCRIPTION

In general terms, a patient classification system (PCS) is a grouping of patients according to observable criteria, or characteristics. Blood type, medical specialty, medical diagnosis, nursing diagnosis, and insurance coverage are just a few of the characteristics that could be used to classify patients.

To date, in Canada, PCS have been most significantly utilized to deploy nursing staff in hospital settings. This approach has helped to:

- determine the appropriate nursing staff mix (RN/LPN);
- plan nursing care assignments (staffing and scheduling);
- match patient needs to nursing resources;
- guide budgetary planning and allocation;
- track trends in patient population and staffing needs;
- develop programs to meet patient needs;
- monitor productivity of nurses, units and facilities;
- measure and track individual, departmental and institutional patient acuity; and,
- link patient diagnosis with acuity of care levels (e.g., not all diabetic patients have the same nursing care requirements)

Currently, the Continuing Care Program has four patient classification systems in place, although they have not been labelled formally as such. These include:

- classifying clients according to the type of direct service worker that can safely meet the care requirements (e.g., HSW, HCA, LPN, RN). This classification is based on the job descriptions contained in the Program's manual. Each position outlines the duties that can safely be carried out by the worker;
- classifying clients according to the type of alternative care that would be utilized if home care was not available (i.e., Levels I to IV). This admission care level is then linked to a cost figure, indicating the home care cost limit that is not to be exceeded for each level (except in specific circumstances outlined in the Program's manual);
- classifying VON nursing care clients, in Winnipeg short-term and long-term care, according to the type of care that is to be provided: supportive, restorative or comprehensive care; and,
- classifying in one Winnipeg region, clients according to the workload they create for the case coordinator.

While each of these classification systems is useful, the Continuing Care Program would benefit from the development of a comprehensive workload measurement system that identifies the intensity of client care (i.e., complexity and magnitude) required, the caregiver level necessary to provide the care and, the workload required to manage the care (i.e., case management). This workload measurement system would assist in providing a better basis for assigning work to staff, for staff planning and for justifying staff utilization. Further, the Program would have better data to monitor and plan for individual, regional and provincial client needs.

There has been a move in the United States to develop patient classification systems for community health providers. The work to date has focused mainly on developing systems to deploy nursing staff within the home health care setting. At the Third National Nursing Symposium on Home Health Care sponsored by the University of Michigan in June 1987, three relatively new patient classification systems were presented. These three systems were also extensively focused on classifying patients in relation to nursing services, with no consideration of their case management implications. In addition, differences between the American and Canadian health care systems render them of little value to the Manitoba Program.

FINDINGS

Staffing levels in the program have not kept up with increases in service volume. Operational budgets have not increased proportionately in relation to the Home Care Assistance Budget. As a result, case coordinators and resource coordinators are currently carrying caseloads and workloads well above provincial standards.

The key variables used to determine the staffing standard for case coordinators were identified as: number of cases, caseload mix, intake and discharge patterns and community resource availability. The staffing standard for case coordinators ranges from 52 cases in Thompson Region to 90 cases in the Winnipeg Regions. The numbers of staff recruited, placed and supervised and the distance travelled in the management of resources were the key variables used to determine the staffing standard for resource coordinators. The staffing standard for resource coordinators ranges from supervising 40 staff in most regions to supervising 45 staff in Winnipeg.

There were four major concerns identified regarding staff workloads. These included:

. no systematic tested basis for current staffing standards;
. high case coordinator caseloads;

- high resource coordinator workloads; and,
- lack of suitable workload measurement and workload management tools.

These findings are summarized in Exhibit 29 at the end of the chapter and are discussed in the following text.

Lack of A Documented Basis For Program Standards

While provincial standards exist for case coordination and resource coordination, the basis for their development is unclear. Ideally, standards should be developed using weighted factors, based on empirical study. To our knowledge there are no program documents outlining the factors and the weight of each factor in determining standards for each region. There were no empirical studies conducted to test the validity of these standards yet they are widely used to determine staffing needs and to assign cases among case coordinators and direct service workers among resource coordinators. While the current staffing standards may be appropriate, without supporting analysis, their validity is questionable. The views of case coordinators across the province varied with respect to ideal caseload. Their figures ranged from 70 to 140 depending on the clientele served. More emphasis was placed on the types of clients in their care rather than the number of clients.

High Case Coordinator Caseloads

Case coordinators across the province are carrying caseloads well above the provincial standard for the region. Table 9 presents the actual and standard caseloads for each region. Only two regions are close to the standard (i.e., more than 90% of standard staffed). Individual case coordinators handle the increase in various ways. There are, however, certain consistent implications of large caseloads that were noted across the province:

Table 9

ACTUAL AND STANDARD STAFFING STANDARDS FOR CASE COORDINATORS AND RESOURCE COORDINATORS IN TEN REGIONS USING END OF DECEMBER 1987 CASELOAD

	Case Coordinator Staffing Standard		Resource Coordinator Staffing Standard	
Region	Standard	Actual	Standard	Actual
Norman	56	72	40	29
Thompson	52	66	40	58
Interlake	56	94	40	50
Parklands	65	85	40	40
Central	64	69	40	51
Eastman	59	91	40	60
Westman	69	75	40	57
Winnipeg S.	90	*	45	*
Winnipeg N.	90	117	45	55
Winnipeg W.C.	90	*	45	*

*Caseload calculated on a single Winnipeg Region

- when stressed, it is easier to admit than not admit a client (Ontario Home Care has calculated that admissions take one hour and non-admissions take two hours). As well, it is easier to put in services than it is to reduce or not put in services;

- the program's standard of reassessments every three months is not followed, potentially resulting in inappropriate levels of servicing and client service dependency;

- tasks usually performed by case coordinators are delegated to others (e.g., relying on direct service worker assessments to determine client needs and service provision);

- the comprehensiveness of assessments are questionable - staff spent little time on initial assessments, as evidenced by chart documentation;

- staff morale is low which could contribute to high staff turnover rates;

- little time is spent on preventing problems - crisis management takes priority;

- delays occur in providing services (e.g., intake assessment takes two to three weeks for non-urgent clients in Winnipeg); and,

- minimal time is spent on counselling or health teaching even when the need is evident.

Although we are unable to assess the costs of high caseloads, there are serious cost implications given the case coordinators response to large caseloads (discussed above). There are also concerns regarding the creation of service dependent clients when reassessments do not occur in a timely manner. The current caseload size compromises the degree to which frequent reassessments and subsequent service reductions can take place.

High Resource Coordinator Workloads

As with case coordinators, resource coordinators are also working above the Program standard for their region. Table 9 shows the actual and standard workload for resource coordinators. Only two regions manage to achieve 100% of standard staffing. Resource coordinators reported that high workloads mean:

- direct supervision of service providers is inadequate, and, at times, non existent;
- direct service worker access to supervisors is limited and insufficient;
- client needs and service provider skills are not well matched;
- performance appraisals of direct service workers are not carried out;
- delays occur in initiating or changing services;
- unauthorized services may be provided (e.g., heavy house cleaning); and,
- personal introductions of workers to clients by resource coordinator is not possible.

In addition to the cost implications of providing unauthorized services, the quality of service delivered by front line workers may be questionable when minimal supervision is provided. While the client survey results do not support the statement that less than quality care is provided, the direct service worker survey and focus group data do support the need for more supervision at the field level.

Lack of Workload Measurement Tool

We have reviewed the literature on home care case management and examined several other jurisdictions with regard to workload measurement and patient classification. To this point, we have not been able to identify any comprehensive workload measurement tools for home care case management that will be suitable for adoption in Manitoba.

If, as case coordinators and program managers stated, caseload count is an insufficient indicator for determining workload, the program would benefit from a viable and valid workload measurement method for the case coordination function. One region has attempted to develop and apply a workload measurement tool (Appendix S). However, inconsistent use of the tool and the lack of information regarding its use renders an assessment of its effectiveness/usefulness impossible.

Ontario's Home Care Program also is struggling with the lack of a workload measurement tool. The Program uses the staffing standard of one case manager to a caseload of 80. In contrast to Manitoba, monthly caseload in Ontario is calculated by:

- determining the number of clients carried over from the previous month;
- adding the number of admissions in the month;
- adding the number of clients assessed but not admitted to the Program in the month; and,
- subtracting the number of discharges in the month.

The Ontario monthly caseload calculation described above allows for some measure of the work created with client flow in the Program. It is, however, possible that a caseload of 80 in Ontario equals a caseload count of 50 in Parklands if the case coordinator was responsible for discharging ten clients, admitting five clients and carrying over 55 clients from the previous month.

Although the Ontario Home Care Program has attempted to account for workload, they also are currently seeking the development of a workload measurement tool. They cited the inability to capture client level of care, to capture time spent on agency coordination, and, to capture the complexity of clients in large urban centres as inadequacies with the current measure.

In British Columbia, care coordinators are responsible for assessing and authorizing levels of ongoing care in facilities as well as in the community. Their caseloads range from around 200 to 500. While being assigned to specific Long Term Care facilities in their area makes assessments of large caseloads a little easier, routine reassessments every six months are compromised because of the large caseloads.
A workload measurement tool could assist in assigning new cases/workers to staff, evaluating staff performance, equitably establishing resource needs inter/intra region, and explaining budget variances. The lack of a tool means that there is no concrete basis for determining future resource needs, resource consumption, appropriate and equitable staff assignments, or staff performance capabilities.

Continuing care staff from across the province suggested the following indirect (non-client-related), direct (client-related) and administrative workload measurement indicators.

The indirect/non-client related indicators are:

- resource development;
- region/area/geography, including travel time;
- community resources available;
- intake rate;

- community history of client demands;
- relationship between institutions and program;
- hospital discharge planning;
- personal experience/background/skills; and,
- chart recording.

The direct/client related indicators are:

- client profile - diagnosis/prognosis;
- client risk;
- service frequency;
- service type;
- family support/non support;
- average time spent with individual clients;
- number of cases; and,
- level of care.

The administrative indicators are:

- meeting time and responsibilities;
- reports (agency, program statistics); and,
- staff supervision/contact.

OPTIONS

In light of the review findings the following suggestions should be considered:

- undertake an empirical study to validate existing staffing standards;
- review and test the existing Winnipeg South workload measurement tool to determine its effectiveness and possible use province wide; and,

. develop a province wide workload measurement tool. However, it should be noted that the development of a viable workload measurement/patient classification tool for the case management function would represent a major contribution to the state of the art in this area and could, potentially, represent a major undertaking. It would require considerable expert input, as well as extensive field testing and validation.

Exhibit 29

SUMMARY FINDINGS : STAFF WORKLOADS

ISSUES/CONCERNS	IMPLICATIONS	OPTIONS/SOLUTIONS
1. Lack of workload measurement tool	. unequal staff assignments . poor planning for resource needs . unable to justify resource consumption	. review existing Winnipeg South tool . develop province wide workload measurement tool . test two respective tools
2. No systematic tested basis for staffing standard (case coordinator /resource coordinator)	. inappropriate resource allocation . staff frustration - unable to meet standard	. undertake empirical study to determine and validate appropriate standards
3. High caseload (case coordinators)	. staff burnout/frustration . service delays . lack of reassessments . failure to take clients off services . reliance on high level professional to compensate for less frequent case coordinator/client contact . client dependency on service . inappropriate delegation of reassessments to direct service nurses	. increase case coordinator staffing levels
4. High workload (resource coordinators)	. delays in initiating and modifying services . unauthorized services provided . minimal supervision of direct service workers . inadequate contact between client and resource coordinator	. increase resource coordinator staffing levels

STAFF WORKLOADS: RECOMMENDATIONS

1. THE OFFICE OF CONTINUING CARE SHOULD COMMISSION A PROJECT TO: A) IDENTIFY AND REVIEW EXISTING TOOLS FOR USE IN MANAGING CASE COORDINATOR AND RESOURCE COORDINATOR WORKLOADS; AND B) DEVELOP, TEST AND COMPARE PROVINCE-WIDE WORKLOAD MEASUREMENT TOOLS FOR CASE COORDINATORS AND RESOURCE COORDINATORS RESPECTIVELY.

2. UNTIL NEW WORKLOAD MEASUREMENT METHODS ARE DEVELOPED AND APPLIED, THE DEPARTMENT SHOULD ADOPT INTERIM MEASURES TO STAFF TO THE CURRENT WORKLOAD STANDARDS. TO AVOID ANY COMMITMENTS THAT WILL NOT BE SUPPORTED BY FUTURE STANDARDS, ADDITIONAL STAFF SHOULD BE HIRED ON A TERM BASIS.

18. DIRECT SERVICE WORKERS

BACKGROUND

The review was directed to gather input from the direct service workers providing home care services on their views of the Program and their general work morale. As described in Chapter 3, direct service worker input was attained through a mail out survey questionnaire (n = 3,600) and four focus groups.

This chapter will describe the services provided by the direct service workers and findings from the questionnaire and focus groups. Summary findings are presented in Exhibit 30 at the end of the chapter.

DESCRIPTION

The direct service workers of the Home Care Program include:

. Registered Nurses;
. Licenced Practiced Nurses;
. Home Support Workers;
. Home Care Attendants/Orderlies;
. Daily Home care workers; and,
. Overnight Home care workers.

Each category of direct service workers has a specific function within Home Care, described below.

The Registered Nurses are utilized to provide nursing care when the health status of the client is clinically unstable and/or when the skills of a registered nurse are required. The Licensed Practical Nurses are utilized to administer nursing care to clients who are clinically stable. Home support workers provide supportive client care such as laundry, house cleaning, and meal preparation whereas home care attendants provide personal care (e.g., bathing, feeding). The daily home care worker provides personal care and home support care as necessary during the day time hours and provides personal care on call during the night time hours. The overnight home care worker is placed overnight in the home of the client to provide authorized personal care and home support services on an on-call basis.

QUESTIONNAIRE FINDINGS

Approximately 3,600 questionnaires were mailed out in December 1987 and a response rate of 36.4% (i.e., N = 1,311) was attained. Appendix T contains the figures and tables displaying the findings discussed in this Chapter.

The workers were asked to identify the type of work they were employed to do and their location of employment. Ninety percent of the respondents were Home Care Attendants and Home Support workers and less than 10% were nurses. Approximately 40% of the respondents were employed in a city, 42% in a town and 18% in a rural area. As a result of the type and location of workers responding to the questionnaire, findings may not be generalized to all home care workers.

The workers also were asked if they required specialized training to carry out their work. One hundred percent of the nurses and 68% of the home care attendants answered affirmatively Less than 32% of the remaining worker categories believed they needed special training. Of those workers indicating that specialized training was necessary:

- 100% of nurses received their training prior to starting with the program;
- 64% of home support workers (HSW) and 79% of home care attendants (HCA) received their training through the Red River Community College (HSW and HCA course respectively); and,
- 29% of overnight workers took the HCA course through the College before starting to work with the Program.

Respondents also were asked to comment on the adequacy of direct servic worker training. Overall, 89% of the direct service workers indicated that their training was adequate. Of the 11% who believed additional training was required, 42% of the home care attendants reported that they had little training, and 27% of the home support workers and 50% of the overnight workers reported a need for emergency training. Overall, workers appear to feel comfortable carrying out home care services given their training. The data suggest that the Program should continue to provide the current training programs.

When workers were asked if they were able to maintain their skills, more than 80% of the nurses and 93% of the non-professional workers answered yes. Of those who responded negatively, over 50% believed their skills were under utilized. Given that 19% of the nurses reported an inability to maintain their skills, there may be a need for ongoing refresher courses/lectures/in-service training. The findings also raise the question of whether or not tasks currently performed by nurses could be handled by non-professionals. It is possible that nurses are feeling under-utilized because they are performing routine tasks that could be delegated to home care attendants.

The questionnaire asked workers how they received their work instructions. In theory, the case coordinator is responsible for determining the tasks to be performed, communicating this to the resource coordinator, who in turn is responsible for instructing the direct service workers. In fact, in many regions, task sheets outlining authorized services are used by the coordinators to inform workers of the client services to be provided.

Results relating to the question of work instruction are as follows:

- less than 25% of the non-professional staff receive written instruction;
- more than 30% of all workers receive verbal work instructions; and,
- between 10% and 16% of the nursing staff receive work instructions from a physician or another nurse.

While the respondents did not clarify the type of instructions received from physicians, it is likely that these instructions related to medical treatment (i.e., dressings, medications).

Approximately 30-50% of workers stated that they received their work instructions from the coordinator without specifying whether the individual was the case or the resource coordinator. This lack of specificity makes it difficult to comment on the appropriate use of case coordinators and resource coordinators for work instructions. However, it is possible that case coordinators are spending inappropriate time on work instructions for direct service workers.

It is also possible that verbal instructions result in misinterpretation and/or unauthorized service provision. However, over 87% of direct service workers responded that their work instructions were clear. Of the 13% of workers who reported that work instructions were unclear: the professionals wanted more client information, and the non-professionals wanted written instructions as well as more client information. Clarifying work instructions can be time consuming for both the coordinators and the workers.

Over 75% of the professional workers contact the resource coordinator when they require clarification of work instructions. Approximately 40-50% of the non-professional workers contact the case coordinator for work instruction clarification and a smaller percentage of both professional and non-professional workers will contact the schedule clerk (responsible for scheduling worker's hours).

The above data suggest that case coordinator time may be inappropriately used to clarify work instructions. Written task sheets for all direct service workers may minimize the need for telephone clarification of tasks.

The majority of workers outlining the procedure to follow if client condition changes, identified the case coordinator as the program staff member to contact. Other workers would contact the resource coordinator, and a smaller percentage of workers would contact the schedule clerk or medical personnel. Clearly, program staff are notified of client changes.

When asked what they did not like about their work with the Home Care Program, workers' dissatisfactions were generally in the areas of administration, job related, client related, or something else.

Administration dissatisfactions related to those items that dealt with specific areas of direct service work management such as hours of work, benefits, wages, and travel allowance. Job related dissatisfactions dealt with the direct service worker's day to day activities and included supervision, tasks, and instructions. Client related dissatisfactions dealt with concerns involving clients such as client assessment, client information, difficult clients, and family involvement. Other related dissatisfactions were items that did not fall in the above three groupings and included items such as career path, ombudsman, and public education.

Generally, the majority of workers from each worker category (40-62%) cited administrative dissatisfactions when asked what they did not like about their work with Home Care. They wanted more hours, less split shifts, better benefits, less travel, better allowance, higher wages and so on. The next largest grouping was job related dissatisfactions (13-28%). Workers wanted more time to complete tasks, better communication, more continuing education, less task restriction, and more recognition and input into client assessments. Only a small percentage of workers from each category (4-16%) wrote of their dissatisfaction in client related areas. Workers wanted more client involvement and more client personalized time.

FOCUS GROUP FINDINGS

Four focus groups were held with direct service workers. The agenda is contained in Appendix F and the findings are summarized in this section under the following headings:

- Orientation and Training;
- Work Assignments;
- Client Assessments;
- Improvements to Program;
- Job Dissatisfactions; and,
- Job Satisfaction.

Appendix U contains the summary points discussed in this chapter.

Orientation and Training

Direct service workers from three of the four focus groups stated that Program orientation was inadequate. They offered the following examples of inadequacies:

- one worker met twelve clients in one day and was expected to remember their care needs for the next day;

- a majority of workers reported that a formal orientation program did not exist;
- several workers did not meet their supervisor, or the case coordinator; and,
- several workers reported being called and given a client's name and address and the tasks they were to perform for the client without ever having met the client.

The one group of workers who spoke of adequate orientation explained that they were introduced to all new clients by their supervisors and they received a formal orientation session. The orientation session included the objectives of the Program and the role of the direct service worker in meeting the Program's objectives. As well, office staff were met in person. Other regions might consider adopting this formal orientation process for workers.

Inadequate continuing education was also mentioned by workers in all four focus groups. This comment usually originated from professional staff who believed it important to maintain their professional skills. Non-professional staff also requested inservices on general topics affecting their work (e.g., AIDS).

Our field work also indicated that there is no provincial policy or procedure manual for direct service workers that addresses client care or practices.

Work Assignments

Direct service workers reported that work assignments were generally fair. However, in dealing with day-to-day assignments, there were concerns expressed in the areas of communication, supervision, client information, and scheduling. Specifically, the workers talked of the need for more communication among themselves and better communication between themselves and the Program staff. They wanted to understand the client care plan and the role they and others assumed in promoting client independence. They also felt a need occasionally to share their client experiences with others (e.g., death of a client).

Workers, especially non-professional workers, expressed the need to improve both the frequency and degree of supervision. Many workers were not satisfied with the annual performance appraisal visit. They wanted ongoing feedback regarding their performance. In addition, they believed this would eliminate the provision of non-authorized services. Further, they wanted supervisors who understood the difficult situations workers encounter and supervisors who could develop realistic strategies to deal with the situations (e.g., clients/families who ask for non-authorized services).

As for client information, non-professional staff expressed the need to know more about their client's condition especially as it related to their role in the home. Take for example a diabetic client receiving meal preparation. Several workers reported that they were not informed of the diabetic status of the client until the client or family informed them. Similarly, professional staff expressed the need for detailed client information before being asked to care for a client.

Scheduling concerns related to the excessive travel asked of workers, the inadequacy of the travel allowance, the insufficient number of work hours, and the number of split shifts scheduled. The following examples demonstrate worker scheduling concerns:

. several workers were asked to travel one hour to a client's home, provide an injection and return. The workers were paid only for the actual time spent with the client and a minimum mileage rate;
. several workers were scheduled to work two hour blocks of time, three times per day. They lived 20-40 minutes away from the

clients homes. Travel time was not paid time;

- a majority of non-professional workers received less than full time employment when they wanted full time hours; and,
- workers were scheduled to care for a client 30 minutes away only to discover another home care worker lived in the client's neighborhood.

Improvements to the Program

Workers suggested a variety of improvements to the Program. These were:

- more client social time. Many clients are socially isolated and look forward to the worker's presence for socialization;
- more time to complete tasks. Not enough time is scheduled to allow completion of tasks or to travel between clients;
- improved client task education. Many clients do not understand the Program mandate specifically as it relates to house cleaning and continuously ask workers to provide unauthorized services;
- improved public awareness. Communities should be aware of the Program and the services offered;
- an ombudsman. A client advocate could assist in investigating service complaints;
- more client/family support. Families could be utilized further to meet client care needs;
- better LPN utilization. LPNs, especially in Winnipeg, could be utilized to provide nursing care to more clients currently cared for by RNs;
- improved office support after hours. Workers wanted program staff available on weekends and after hours to answer questions, clarify instructions, and provide emergency back up personnel for illness;
- easier access to HCA/HSW courses. Not all regions or districts within the regions could readily access the training courses offered by Red River Community College;

- less workers per client. It is not uncommon to have three categories of workers caring for one client. This can be overwhelming for the client and confusing for workers;
- formalized policies and procedures. Professional and non-professional workers wanted reference material available for client procedures (e.g., enemas, hoyer lifts) and policies (e.g., home care attendant working as home support worker);
- a worker career path. The opportunity to make home care a career and move within the Program;
- means testing. House cleaning services could be purchased by those able to pay. Testing could be utilized to determine financial status of clients; and,
- less unsafe working conditions. Workers arriving at clients home unfamiliar with clients needs and/or equipment feel uncomfortable providing care. Professional staff are concerned about the liability of care when written policies and procedures are not available.

Client Assessments

Generally, direct service workers believed that client assessments were appropriate and that clients received the services they needed.

Job Dissatisfactions

Focus group participants responded similarly to questionnaire respondents when asked about job dissatisfaction. They expressed the need for more hours, better wages, and better benefits. They also expressed a desire to be a recognized member of the health care team. Working in isolation in the communities, workers do not often experience the feeling of being a part of the Home Care Program.

Job Satisfaction

Despite their concerns, the direct service workers expressed a high degree of satisfaction working for the Program. They enjoyed helping others, especially the elderly clients, and found it personally satisfying when they could contribute to the Program goal of preventing premature institutionalization. In addition, workers enjoyed the flexible hours of work.

The impending unionization of the direct service workers will probably address many of the administrative concerns identified in this chapter (i.e., wages, benefits, hours of work, scheduling practices, travel requirements and reimbursement and so on). The Department might wish to review some of these issues once the unionization process is completed.

Several recommendations are put forth to deal with issues other than administrative concerns expressed by the workers. The recommendations address the education, communication and supervision issues identified in the survey and focus group data.

Exhibit 30

SUMMARY FINDINGS: DIRECT SERVICE WORKERS

Variable	Findings	Implications
Employment Location	. majority of respondents from cities and towns. . majority of respondents were non-professionals. . four regions represented in focus groups	. rural area direct service workers and professional nurses may have different needs/concerns than those expressed in this report.
Need for Specialized Training	. 100% of nursing professionals believed their specialized training was necessary. . 58% of home care attendants believed training was necessary and 79% took HCA course through the Program. . >65% of home support, overnight and daily homemakers did not believe special training was necessary yet over 50% of these workers took the Program courses. . >85% of workers reported their training was adequate to carry out their tasks, however, 14% of home care attendants felt inadequately trained.	. continue to provide HCA and HSW training courses. . some home care attendants may require additional task training.
Adequacy of Training	. Emergency and general training were identified as areas for additional training needed by workers. . orientation inadequate.	. emergency training necessary for all workers. . potential unauthorized service delivery . unaware of program objectives
Skill Maintenance	. >90% of homecare attendants/home support workers reported skill maintenance capabilities . 19% of nurses did not feel able to maintain skills. Of these, >50% believed they were under utilized.	. professional nursing refresher courses/lectures/inservices may be required in some areas . raises the question of whether tasks presently undertaken by professionals could be handled by non-professionals.

Exhibit 30

SUMMARY FINDINGS: DIRECT SERVICE WORKERS (cont'd)

Variable	Findings	Implications
Work Instructions	. <25% work instructions are written. . instructions generally received verbally from coordinators (resource and case coordinators)	. potential for misinterpretation /miscommunication and unauthorized service provision. . case coordinators spending time outlining instructions rather than coordination.
Clarity of Work Instructions	. >85% of workers reported receiving clear work instructions. . 12% of home care attendants stated they did not receive clear instructions.	.potential for home care attendants spending time clarifying instructions or carrying out unauthorized services.
Clarifying Work Instructions	. >75% of nurses contacted resource coordinators for clarification. . >40% of home support workers/ home care attendants contacted case co rdination for clarification. . majority of workers suggested that instructions should be written.	. potentially poor communication between resource and case coordinators. . inappropriate use of case coordinators and resource coordinators.
Procedure When Client Needs Change	. >70% of home support workers/ home care attendants would contact either the case coordinator or the resource coordinator . nursing staff more likely to contact medical personnel.	. program staff notified of client changes.
Areas for Improvement	. majority of workers wanted administrative changes - more hours, better benefits, higher wages. . some workers suggested improvement with day to day activities such as proper supervision, fewer mundane tasks, written instructions. . a small group of workers mentioned need for client related improvements - more information, more family involvement.	. good workers may leave program. . inadequate supervision may result in unauthorized service delivery. . more family involvement.

Exhibit 30

SUMMARY FINDINGS: DIRECT SERVICE WORKERS (cont'd)

Variable	Findings	Implications
Job Satisfaction	. majority of workers expressed high degree of personal satisfaction working with elderly. . enjoyed flexible hours. . workers generally found resource/case coordinators helpful.	

DIRECT SERVICE WORKERS: RECOMMENDATIONS

1. THE DEPARTMENT SHOULD CONTINUE TO PROVIDE THE HOME CARE ATTENDANT/HOME SUPPORT WORKER COURSE THROUGH RED RIVER COLLEGE. THIS COURSE SHOULD BE EXPANDED TO INCLUDE EMERGENCY TRAINING (E.G., CARDIO PULMONARY RESUSCITATION AND EMERGENCY FIRST AID) AND BE AVAILABLE TO ALL WORKERS IN THE PROGRAM.

2. REGIONAL OFFICES SHOULD DEVELOP AND MAKE ACCESSIBLE TO DIRECT SERVICE WORKERS A LOCAL POLICY AND PROCEDURE MANUAL ADDRESSING CLIENT CARE PRACTICES. THIS MANUAL SHOULD BE UPDATED REGULARLY.

3. EACH REGIONAL OFFICE SHOULD DEVELOP AND IMPLEMENT A FORMAL ORIENTATION PROGRAM FOR ALL DIRECT SERVICE WORKERS. THIS PROGRAM SHOULD INCLUDE, AS A MINIMUM, AN OVERVIEW OF THE CONTINUING CARE PROGRAM'S GOAL AND OBJECTIVES, LOCAL POLICY AND PROCEDURE INFORMATION, EMERGENCY PROTOCOLS, AS WELL AS AN INTRODUCTION TO OFFICE AND PROGRAM STAFF. THIS RESPONSIBILITY SHOULD BE DELEGATED TO THE RESOURCE DEVELOPER. DIRECT SERVICE WORKERS SHOULD NOT RECEIVE CLIENT ASSIGNMENTS UNTIL THEY HAVE COMPLETED THE ORIENTATION PROCESS.

4. REGIONAL OFFICES, IN CONSULTATION WITH THE OFFICE OF CONTINUING CARE, SHOULD PLAN AND IMPLEMENT A CONTINUING EDUCATION PROGRAM FOR ALL DIRECT SERVICE WORKERS ENSURING THAT KNOWLEDGE AND SKILLS ARE MAINTAINED AND UPDATED (INCLUDING REGULAR CARDIO PULMONARY RESUSCITATION CERTIFICATION AND EMERGENCY FIRST AID UPDATES). THE OFFICE OF CONTINUING CARE SHOULD ENSURE THE PROGRAM RESOURCE SPECIALIST OVERSEES THIS PROCESS.

5. ALL WORK INSTRUCTIONS TO DIRECT SERVICE WORKERS MUST BE IN WRITING, PROVIDING SUFFICIENT CLIENT INFORMATION TO ENSURE SAFE, APPROPRIATE CARE. WORK CLARIFICATION QUESTIONS SHOULD BE DIRECTED TO THE

RESOURCE COORDINATOR WHO, IN TURN, SHOULD CONTACT THE CASE COORDINATOR FOR FURTHER CLARIFICATION IF NEEDED.

6. DIRECT SERVICE WORKERS, WHEN APPROPRIATE, SHOULD BE INVOLVED IN CLIENT CASE CONFERENCES.

7. REGIONAL OFFICES SHOULD ENSURE THAT ALL DIRECT SERVICE WORKERS RECEIVE REGULAR IN-PERSON FEEDBACK ON THEIR PERFORMANCE. A FORMAL PERFORMANCE APPRAISAL SHOULD BE CONDUCTED ON AN ANNUAL BASIS.

8. REGIONAL OFFICES SHOULD ASSIGN PROGRAM STAFF TO DEAL WITH DIRECT SERVICE WORKERS' QUESTIONS/DILEMMAS AFTER WORKING HOURS AND ON THE WEEKENDS. THE DIRECT SERVICE WORKERS SHOULD BE INFORMED, IN ADVANCE, OF WHOM TO CONTACT AFTER HOURS.

19. CLIENT SERVICES

As outlined in the Policy Guidelines - Continuing Care Program - the scope of services within the program is broad, covering a range of health treatment services: nursing, personal care, therapy, home support, health promotions, social, volunteer, and supply.

Personal care services include activities such as the assistance with client bathing, shaving, mouth care, foot care, toiletting, skin care, and so on. Therapy services include both physiotherapy and occupational therapy. Home Support services include assisting the client with activities of daily living, light housekeeping, essential laundry and meal preparation. Health promotion services include activities to assist the client in attaining the highest possible level of health. Social services can include social counselling by social workers and/or participation in social activities such as the Adult Day Care Program, congregate meals, and so on. Volunteer services such as Friendly Visitors, Meals on Wheels, Handyman Services, and Medical alert can be arranged for the client. Finally, support services required for the delivery of Home Care (e.g., dressings, medical equipment) can be accessed by the client.

In the case of housekeeping services, the government is currently encouraging the development of independent not-for-profit housecleaning agencies in selected areas of the Province. Such agencies would provide services directly to clients and would not be reimbursed by the Home Care Program. They could reduce the extent of reliance on Home Care for housecleaning services.

Home Care services are put into place to maintain an individual in the home environment and can be delivered both in the home or outside the home (e.g., Day Care and Respite Care). Adult Day Care and Respite Care are two programs funded by the Manitoba Health Services Commission but accessed through the Continuing Care Program. These programs are described further in Appendix V. In all client cases, the service is to be provided by the professional category with the minimum skill required to provide the services.

The cost of the Home Care Services, however, should not exceed the cost to government of alternate placement except in specific instances. Examples include clients awaiting placement, temporary need for additional care, terminal care, or approved special cases.

The cost limits used with each level of care in a Personal Care Home are set annually by the Office of Continuing Care on cost figures provided by MHSC. The figures are based on the previous year's costs. The limits take into account the cost of each level of care in a PCH, less the charge paid by the residents and are expressed as a monthly cost. Personal Care homes do not establish costs for a level IV client. As a result, level III and IV are combined as one category. When only three levels of care are used, the need for a fourth level is unclear.

The cost of home care services is calculated using direct home care service cost and excludes regional staff services, agency services, and supplies/equipment. As of July 1, 1987 the following monthly costs were used to determine the cost limits for home care services:

Level I	-	$ 927
Level II	-	$1,452
Level III/IV	-	$2,010

As well, service rates used to determine the direct service costs relative to cost limits, were provided by unit cost and service type. It is important to note several other guidelines regarding client services:

. available human resources determines service availability;

- . priority need cases are serviced first if services are in short supply;
- . clients are to be taught methods of self care other than using formally provided services;
- . available manpower must be maximized (e.g., having one category of worker perform tasks from other categories of workers); and,
- . volunteer services are to be recruited and used to complement paid services.

FINDINGS

In our review of the Program five major concerns regarding client services were identified:

- . self-care clients are penalized regarding supplies;
- . over servicing of clients requiring only house cleaning services;
- . over servicing (service type and volume) of nursing services in Winnipeg;
- . inconsistent availability of alternate services and potential resources across the province; and,
- . not capturing all community service costs in comparing them with institutional costs.

Self-Care Client Penalties

Several continuing care staff reported that self care clients are penalized for their independence. If a client is self care in the use of supplies, they are ineligible for provision of supplies under the Home Care Program. Therefore, self-care could result in a hefty cost for the client, minimizing his/her motivation for independence and the case coordinator's desire to teach self-care methods.

Using incontinence pads as an example, the Continuing Care Program pays $32.00 for a one box supply of pads, based on bulk purchase orders. If the clients learn to use the pads themselves they must pay approximately

$60.00 from the local pharmacist. As a result of these costs, not only is there little client incentive to learn self-care, case coordinators lack desire to teach self-care methods for needy clients. This results in unnecessary service to self-care clients and client dependency. Both of these outcomes have cost implications.

A review of the present self care policy in relation to supplies is warranted. The review should identify workable solutions for self care clients.

Over Servicing Housecleaning Only Services

In February, 1987 a supplement to the program Manual was issued. The supplement dealt with the household maintenance guideline and outlined Home Care's policy relative to household maintenance. This service is to be provided if:

. client frailty consumes all activity of daily living; or,
. client is physically unable to perform tasks; and,
. there are no individuals living nearby who can realistically perform the tasks; and,
. non-profit community services are not available.

If the assessor is still unsure of client's ability to perform these tasks, he or she should ensure pertinent clinical data are considered and a therapy assessment is completed where appropriate.

In addition to outlining the policy, the supplement outlined Home Care's expectation of family and other household members, guidelines in the use of community resources/commercial services, and the assignment of cleaning and laundry. Despite these clearly articulated guidelines, many case coordinators authorizing client services reported feeling uneasy at not putting in house cleaning services. The consultants were informed by program staff that in the public's mind, home care is synonymous with home cleaning. This makes service reduction difficult especially when the client survey demonstrated that homemaking services were the most valued service.

Case coordinators also reported that neighbors, friends, family and clients do not understand the scope of Home Care's mandate to provide a safe environment. In the past home cleaning was provided every other week and now, with the new guidelines, it is shifting to once every three weeks. Consequently, case coordinators who are stressed from over work, opt to authorize house cleaning rather than deal with client/family complaints or community pressures resulting from house cleaning service reduction.

The Program has already identified the need to take action against potential over servicing of housecleaning services. Action includes caseload review of the 10% clients receiving only housecleaning services across the Province, clearer guidelines with respect to Program eligibility criteria and heightened awareness of the issue.

Over Servicing Nursing Services in Winnipeg

The issue of potential over servicing in nursing services in Winnipeg has been discussed in Chapter 8 (Client's View of the Program) and will be discussed further in Chapter 20 (VON).

Inconsistent Availability of Resources

There are regions in the province that have difficulty attracting and retaining qualified workers and lack a variety of specialized services. The following are not always available in all districts of the regions:

- adult day care;
- respite care;
- non profit cleaning;
- meals on wheels;

- therapy services;
- professional nursing services; and,
- volunteer transportation.

Clients living in rural areas cannot access the same resources as their counterparts in urban areas. This unequal access to resources raises two concerns: equality of client services, and the cost of undeveloped community resources.

Home Care is a non-guaranteed service in the sense that available human resources determine service availability. If resources are unavailable the program objective to prevent unnecessary institutionalization is questionable in the particular service setting. If, for example, day care and respite care are non-existent, clients may require institutional care sooner. In addition, the lack of therapy services in the Northern regions may also mean premature institutionalization due to the lack of non-comprehensive assessments, treatment, and knowledge regarding alternative methods of care.

Furthermore, the cost of undeveloped community resources has yet to be studied. Client access to non-profit cleaning, meals on wheels, and transportation would reduce the cost of home care services and further reduce premature institutionalization. In one area, for example, where a community non-profit cleaning service was developed, Program cost savings were realized when nine clients were discharged from the Program.

Given the inconsistent availability of resources across the Province, the Continuing Care Program should give consideration to:

- utilizing caseload review data to identify service gaps and resource deficiencies across regions;
- examining the cost effectiveness of two alternative strategies: purchasing services or developing community resources (e.g.,

resource development grants, resource development information and consultation); and,

- establishing additional incentives to attract professionals to the North and remote areas (e.g., educational packages, and housing).

Calculation of Home Care Cost Limits

As previously described, the cost limits established for Home Care exclude regional staff services, agency services and supplies/equipment. Further, the cost limits established are not based on up-to-date MHSC financial information (i.e., they are approximately 15 months old). In the absence of computerized client information, it is difficult to calculate the actual costs of Home Care as an alternative to institutionalization. However, the actual cost of Home Care likely will exceed institutionalization when agency services (e.g., daycare, respite care), case management, and supplies and equipment are included. Justifying the Continuing Care Program on the basis of a cost-effective alternative to institutional care will be discussed in chapter 19.

An approach to calculating community costs, when developed, will assist in determining whether or not Home Care is less costly than institutionalization.

A summary of the Review findings regarding client services is in Exhibit 31, following.

Exhibit 31

SUMMARY FINDINGS : CLIENT SERVICES

ISSUES/CONCERNS	IMPLICATIONS	OPTIONS/SOLUTIONS
1. Self care clients penalized regarding supplies	. no incentive to teach/learn self care methods . unnecessary service to clients capable of self care . cost implications . fosters dependency	. review self care policy in relation to supplies with view to identifying workable solutions
2. Potential over servicing Housecleaning only services	. client dependency . cost to provide care . public misunderstanding of program scope . poor client relations in event of service reduction	. continue caseload reviews . develop more non-profit cleaning services . fee-for-service charge for cleaning . strict adherence to eligibility criteria on admission
3. Perceived over servicing of nursing services in Winnipeg (VON) - both service type and volume	. cost to provide care . client dependency . LPNs are dissatisfied because program not using them to full potential	. improved VON accountability
4. Inconsistent availability of alternate services and potential resources . shortage of professionals . absence of day care, respite care . meals on wheels	. unequal service access . lack of social work input for assessments . potential for premature institutionalization due to lack of community resources . cost to provide home care when community resources not available	. use caseload review data service gaps and resource deficiencies . prepare strategy for development of community resources - resource development grants - resource development information and consultation . incentive to recruit professionals to the North and remote areas
5. Not capturing all community service costs in comparing with institutional costs	. home care alternative may be more expensive than institutionalization	. develop approach for calculating community costs

CLIENT SERVICES - RECOMMENDATIONS

1. THE OFFICE OF CONTINUING CARE SHOULD REVIEW THE POLICY REGARDING SELF-CARE PATIENTS IN RELATION TO THE PROVISION OF SUPPLIES. A SOLUTION SHOULD BE SOUGHT WHICH MOTIVATES CLIENTS TO ASSUME SELF CARE.

2. THE OFFICE OF CONTINUING CARE SHOULD USE CASELOAD REVIEW DATA TO IDENTIFY GAPS IN COMMUNITY RESOURCES ACROSS THE PROVINCE AND SUBSEQUENTLY SHOULD ASSESS THE RELATIVE COST EFFECTIVENESS OF TWO ALTERNATIVE STRATEGIES:

   - CONTINUE TO HAVE THE OFFICE OF CONTINUING CARE PURCHASE SERVICES IN SPECIFIC COMMUNITIES; AND

   - CONCENTRATE EFFORTS ON DEVELOPING INDEPENDENT SERVICE RESOURCES (E.G., MEALS ON WHEELS)

3. THE DEPARTMENT SHOULD EXPLORE PROVIDING ADDITIONAL INCENTIVES TO RECRUIT PROFESSIONALS TO THE NORTHERN AND REMOTE AREAS OF THE PROVINCE.

4. THE OFFICE OF CONTINUING CARE SHOULD CLARIFY THAT THE SERVICE LEVEL LIMITS DO NOT TAKE INTO ACCOUNT THE COSTS OF THE FULL RANGE OF COMMUNITY SERVICES. (SPECIFICALLY, THEY DO NOT INCLUDE CASE MANAGEMENT, DAY CARE, RESPITE CARE, COMMUNITY THERAPY SERVICES, SUPPLIES AND EQUIPMENT.)

20. THE VICTORIAN ORDER OF NURSES

BACKGROUND

The Victorian Order of Nurses (VON) for Canada is a national voluntary community health agency. The Winnipeg Branch of VON has served the City of Winnipeg since 1901, essentially providing nursing services in the home on a visit basis. VON services are available twenty-four hours a day, seven days a week.

On April 1, 1974 a province-wide Home Care Program providing both short and long-term care, was introduced under the newly created Office of Continuing Care. The Program was funded by the Department of Health and Social Development and the VON was designated to coordinate short term care in Winnipeg.

The VON/Continuing Care Program relationship has endured up to this date. Over 90% of the Winnipeg VON's revenue currently comes from the Continuing Care Program; less than 10% is from other sources such as Veteran's Affairs Canada, Medical Health Services and industry contracts. Program spending on VON represented 22% of the Home Care Assistance budget in the 1986/87 fiscal year. The proportion of the Home Care Assistance Budget accounted for by VON has declined steadily since the program's introduction. In 1975/76 and 1976/77 the figure was 31%.

Year	Proportion of the Home Care Assistance Budget spent on VON
1975/76	31%
1976/77	31%
1977/78	33%
1978/79	29%
1979/80	28%
1980/81	25%
1981/82	27%
1982/83	26%
1983/84	25%
1984/85	27%
1985/86	24%
1986/87	22%

The VON role within the Continuing Care Program is depicted in Exhibit 32, following.

The VON is responsible for:

- coordination of Home Care services from the Winnipeg Hospitals. This consists of hospital-based case coordination for selected populations with special medical needs and referrals to the Continuing Care Program and VON short-term care;
- administering short term care (under 60 days) in Winnipeg; and,
- providing direct RN nursing services to long-term care clients (over 60 days) in Winnipeg.

Each of the three major VON functions is described below.

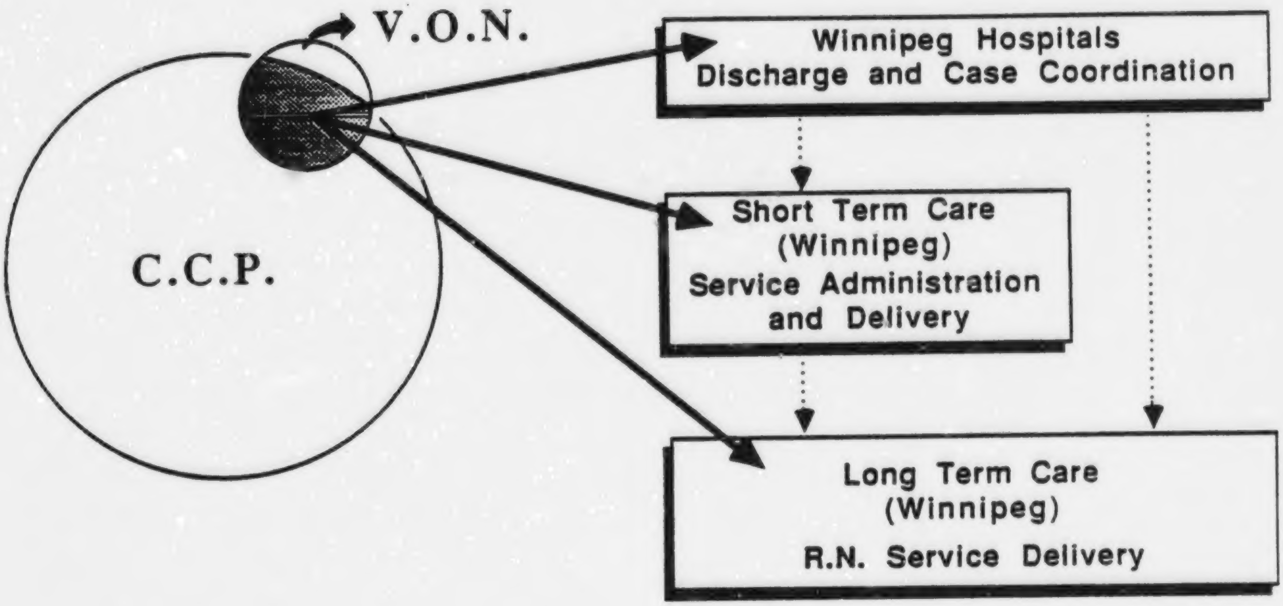
DESCRIPTION

Hospital Discharge and Case Coordination

There are 19 VON staff members working in Winnipeg hospitals functioning as Hospital Continuing Care Coordinators. Although these individuals are employed by VON, they are housed within the hospital. VON is reimbursed

Exhibit 32

The Victorian Order Of Nurses (V.O.N.) and Continuing Care Program (C.C.P.) Relationship


V.O.N.
C.C.P.
Winnipeg Hospitals
Discharge and Case Coordination
Short Term Care
(Winnipeg)
Service Administration
and Delivery
Long Term Care
(Winnipeg)
R.N. Service Delivery

for these services by the hospitals. The hospitals, in turn, submit monthly invoices to the Department of Health (Administrative Services), and are reimbursed through the Continuing Care Program.

It is the responsibility of the hospital continuing care coordinator to:

- determine program eligibility and assess the need for care at home or in a personal care home; and,
- initiate the delivery of a broad range of professional and non-professional services based on the Continuing Care Program guidelines.

Continuing Care Coordinators identify and assess client eligibility for Continuing Care by attending hospital rounds and/or reviewing patient records. Based on their assessment of client care needs, the hospital continuing care coordinator develops an interim care plan and refers the case to either the VON (short term care) or the Community Case Coordinator (long term care). These Continuing Care Coordinators are essentially referral nurses and as such do not manage individual cases.

In addition to the 19 Hospital Continuing Care Coordinators, there are four Hospital Case Coordinators. These positions are staffed by VON nurses and located within the:

- Health Science Centre (one coordinator for adult patients, another for children);
- St. Boniface Hospital; and,
- Municipal Hospital.

These individuals are responsible for case coordination of all VON specialized cases requiring ongoing medical contact with the hospital. They arrange for direct client service delivery from community agencies on an individual case authorization basis.

Short-Term Care

As the designated short term home care coordinating agency, the VON is responsible for:

- applying the Continuing Care program policy and procedures;
- employing staff for delivery of short term home care (registered nurses and homemakers);
- participating in program information, reporting and forms systems;
- relating directly to the Winnipeg regions on matters concerning the interface between short term and long term care;
- relating to the Office of Continuing Care on matters of policy, hospital discharge and service coordination; and,
- relating to the Office of Continuing Care and Administrative Services on matters of budgeting.

Long-Term Care Service Delivery

The VON is also responsible for the provision of direct RN nursing services to the long-term program in Winnipeg. The community case coordinator authorizes VON nursing services for individual clients. VON then submits monthly invoices for services provided and is reimbursed on the basis of a budgeted cost per visit.

FINDINGS

The relationship between VON and the Continuing Care Program is a complicated one that at times gives rise to administrative tensions. On the one hand VON's Winnipeg Branch has been servicing Winnipeg since 1901 and has developed an outstanding reputation for professional community nursing services. Although most of the services now provided by VON are paid for through the Continuing Care Program, VON tends to look on these services as a continuation of its original mission and therefore may expect to be able to continue delivering them with a degree of autonomy.

On the other hand, officials of the Continuing Care Program, see VON's services as part of their broader Program, and raise justifiable concerns about how the VON services comply with Program standards and guidelines. The current role of VON is such that not only is it delivering nursing services under the Program but it also is responsible for care planning decisions that have important repercussions for the rest of the Program, particularly through its hospital referral role. Clearly, with VON so extensively implicated in the Continuing Care Program, officials need to be assured that VON operates in a manner consistent with Program policies and practices.

One question raised at the outset of the review (see terms of reference, Appendix A) concerned the appropriateness of the Continuing Care Program relying on VON for service delivery. Evidence from this review indicates that VON have an important role to play in the program, a role which could not be readily fulfilled by other organizations. Specific advantages of involving VON include:

- Flexibility. By purchasing services from an independent agency, the program is able to secure a high level of flexibility, minimizing staff year commitments and yet securing access to a large base of professional resources;
- Responsiveness. VON has proven able to provide a very quick response to service requests (within 24 hours). There is some question whether such a response could be sustained under program administered services, given their reliance on independent direct service workers to provide services;
- Credibility. Interviews with Continuing Care Program field staff and regional managers found that VON commands a high degree of respect among practicing health professionals;

- Quality Services. VON has a well developed infrastructure for ensuring quality services including its national quality assurance framework and thorough, consistently applied supervision protocols;
- Expertise in Nursing. VON has developed considerable practice expertise and service delivery know-how in acute, and complex care visiting nursing. It might be difficult to transfer responsibility for such services to the Continuing Care Program directly. In particular, the independent provider status of direct service workers would weaken mechanisms for quality assurance and service accountability that are critical in the more complex cases. Based on interviews that were held with health professionals, there is a strong indication that there was a higher proportion of more complex cases in Winnipeg than in the rural areas; and,
- Sound Management. VON has an effective management structure that achieves a high degree of management and service control.

Another issue raised at the outset of the review concerned the appropriateness of VON administering the short-term care program. This concern focused on the potential conflict of interest associated with the juxtaposition of their two roles: orderer of services and provider of services. The review identified several advantages to VON administering the short-term program. The advantages parallel many of the points made above -- flexibility, credibility, quality of service and so on.

The most important advantage of VON administering the short-term program appears to be the opportunity to respond quickly to requests for service on discharging patients from hospital. Other jurisdictions that have separate organizations responsible for case management and the provision of services have experienced problems obtaining adequate responses to home care service requests from hospitals. In Ontario, it generally takes at least 48 hours from the initial service request to the first visit. Local home care programs require 24 hours to respond and order the service, and the service provider then needs another 24 hours to arrange the service. This problem has very important resource implications in that it results in many additional patient-days in hospital that could have been avoided if home care had been able to respond faster and facilitate earlier discharges. In Ontario, this problem has been the prime impetus to proposals for hospital-based home care (as in the Ontario Health Review Panel - Evans Report, 1987) and hospital-in-the-home programs (1987 provincial election promise).

It is also important to recognize the disadvantages of having VON deliver nursing services and administer the short-term program. These include:

- **Lack of direct control**. As with any purchased service arrangement, including reliance on direct service workers, the program sacrifices some degree of control. There is always an understandable concern that the organizations or individuals contracted to deliver services will have their own objectives that do not fully correspond with those of the purchasing program.
- **Distancing program managers from grass roots needs**. By restricting the role of the Continuing Care in Winnipeg to paying for services and case management of the long-term cases, the program is put at greater distance from the service front-line. This could mean that program managers (Regional Continuing Care Coordinators and the Office of Continuing Care) have less opportunity to learn about the needs and concerns of program clients.
- **Continuing Care Program not recognized by public and client**. When VON (or another provider agency) is responsible for delivering services, it is likely that program clients, and the

public in general, will tend to identify the service with the providing agency rather than Continuing Care as the funding program. This may be undesirable both from the perspective of who deserves the credit (or blame) for the program, and from that of the clients and public knowing where to direct concerns and suggestions relating to policy and program management issues.

In drawing conclusions about the appropriate role of VON, the review looked at its role in relation to both service delivery and case management of the short-term program. Exhibit 33, following, summarizes the pros and cons of VON delivering services. On balance, the review concluded that VON's role as a service provider was appropriate and that the arrangement served the Program and the public well. On VON's role in case managing short-term clients, the pros and cons are summarized in Exhibit 34, following. In this instance, the review found that the case for VON's current role is less compelling. It is the conclusion of the review that, on balance, the advantages to having VON administer the short-term program are outweighed by the disadvantages. However, it is also recognized that to have the Continuing Care Program assume responsibility for administering the short-term program would be a major departure from arrangements that have prevailed since the outset of the Continuing Care Program. It would also require the Continuing Care Program to hire at least 24 additional staff as case coordinators and supervisors (based on current caseloads, caseload standards and needs for supervision). In addition, the Continuing Care Program would have to ensure that its staff were adequately trained in short-term and complex nursing to assume these new roles.

In drawing conclusions on the appropriateness of VON's role in delivering services and case managing short-term services, the review identified three areas of concern:

Exhibit 33

THE ADVANTAGES AND DISADVANTAGES OF VON ADMINISTERING (I.E., CASE MANAGING) THE SHORT-TERM PROGRAM IN WINNIPEG

Advantages	Disadvantages
Continuity - VON, historically, has managed the short program and changing this would be disruptive.	Control of services - potential conflicts with VON both ordering and providing services.
Staff years saving to CCP - if CCP were to take over this role it would require an additional 24 or more staff years for new case coordinators, supervisors and other staff.	Conflicting objectives - VON prefers to provide a richer level of services than that indicated by CCP.
Flexibility - avoids the long-term staff commitment of CCP in hiring the additional case management staff.	Division of the short-term and long-term - the separation of short- and long-term components of the program for case coordination purposes can be problematic, particularly where the need arises to transfer patients from short- to long-term.
Expertise - VON staff currently have the most sophisticated expertise and the most experience in complex care.	Does not parallel the rest of the Province - outside Winnipeg no distinction is made between short- and long-term clients.
Responsiveness - VON staff work weekends and have a high commitment to meeting clients' care needs. The agency is also eager to identify and address emerging types of needs.	Less frontline information for CCP - CCP lacks contact with a significant number of program clients and will be less in-touch with emerging needs.
Sound management systems - VON has sound systems for service management.	

Exhibit 34

THE ADVANTAGES VS THE DISADVANTAGES OF VON DELIVERING SERVICES

Advantages	Disadvantages
Flexibility - secure access to a large base of professional resources without making a long-term commitment.	Lack or direct control - "arm's length" administrative relationships with CCP.
Responsiveness - VON's commitment to rapid response to service requests.	Philosophy and standards - sometimes VON philosophy and standards do not correspond to those of CCP.
Credibility - VON highy regarded by the health professional community.	Diminished front line information for CCP - CCP more out of touch with needs and developments on the street.
Expertise - know how and experience in nursing, including complex care.	Credit - CCP does not get the full credit (or blame) for services funded by the program.
Quality assurance - well developed national quality assurance system.	
Management systems - sound management including information systems.	

- VON's Role in Winnipeg Hospitals;
- Lack of Mechanisms to Ensure VON Accountability to Continuing Care Program; and,
- VON Standards and Philosophy Regarding Nursing Services.

These concerns are discussed below and are summarized in Exhibit 35 at the end of this chapter. The findings serve to support the conclusions that the advantages of having VON administer the short term-care Program are outweighed by the disadvantages.

VON's Role in Winnipeg Hospitals

Three specific issues were identified with respect to VON's role in the Winnipeg hospitals:

- VON's ability to influence their work flow due to their role in determining whether a client should receive short-term or long-term care;
- VON's role as representative of the Continuing Care Program to hospital staff; and,
- VON's possible lack of familiarity with managing the full range of services for long-term cases.

i) Ability to influence work flow

There is a perception of conflict of interest concerning VON when they could influence their work flow by referring hospital clients to the short-term care program. Furthermore, inappropriate categorization could lead to increased client transfers to long-term care from short-term care, service disruption and unnecessary paperwork for regional staff.

Concrete criteria for determining the most appropriate coordinating agency have not been developed by the Program. Due to VON's role in making decisions about the need for long- or short-term care and the lack of detailed decision making criteria, there may be a natural tendency to refer clients to the short-term Program due to:

- VON's quick response in providing nursing and homemaking services;
- pressure from hospitals for speedy discharges;
- the security, provided by knowing that clients can always be transferred later from the short- to the long-term care program; and,
- familiarity with and loyalty to VON.

ii) Role as Continuing Care Program Representative

The only Continuing Care Representatives in Winnipeg hospitals are VON nurses. Our review found that communication between the Program and VON often was lacking. Symptomatically, we found that program officials and VON staff were often unaware of the practices of the other party. Two examples are:

- VON staff use the 60 day short-term cut off date as a guideline rather than as a firm rule; and,
- Continuing Care Program officials were, for a period, unaware that VON staff were caring for AIDS patients in the community.

These communication problems between VON and Continuing Care Program could result in a communication breakdown between Continuing Care Program and the hospitals. More importantly, Continuing Care Program lacks information regarding emerging hospital trends when the communication between VON and Continuing Care Program is less than perfect. Without timely accurate information regarding hospital trends in care, Continuing Care Program cannot be prepared adequately to handle client needs. It is equally important to note that VON has a very good and long established rapport with hospital staff and nursing departments. It is likely that some of the hospitals affected would feel uncomfortable if VON staff were replaced with staff working directly for the Program.

iii) Lack of familiarity with managing the full range of services for long-term care

There is a concern that VON hospital nurses may lack knowledge of the full range of community resources and due to their hospital orientation they may also lack an appreciation of the changes in client needs when they return to their homes. A review of the Home Care Program (Home Care Review of 1985) noted the point of entry to the Home Care Program has implications for subsequent utilization of services. Home Care services are put into place by VON staff who have limited knowledge of the client's needs in the home setting. As a result, there is a perception (by rural and urban community case coordinators) that VON initially over services the recently discharged hospital client. The community case coordinators often reduce service frequency (e.g., Homemaking from weekly to biweekly) or change the service deliverer (e.g., RN to HCA) when the client is reassessed in the community. If true over servicing exists, costs are compounded by the fact that there is often a lengthy period before the community case coordinator reassesses the interim care plan established for the long-term care client.

In addition to concerns about over servicing, there is a perception by community cases coordinators that not all long term care referrals originating from the Winnipeg Hospitals are eligible for the Continuing Care Program. Community Continuing Care staff expressed a concern that they are often left to discharge the client from Home Care because of ineligibility. If the intake assessment is not conducted within the two week period post hospital discharge, the client can become dependent on the service and, thus render the case coordinator's mission more difficult.

Both over servicing and ineligible referrals are costly. While there are no hard data to substantiate these perceptions, they do provide food for thought when:

- VON is responsible for 43-63% of all new admissions to Home Care (Table 10);
- VON is responsible for referring 60-70% of the Winnipeg Home Care admissions clients (Table 11); and,
- VON manage approximately 22-25% of Winnipeg's Home Care caseload (Table 12).

VON Accountability

The Continuing Care Program spent approximately $6,157,900 on VON services (Hospital Coordination, Short-Term Care Administration and services in the 1986-87 fiscal year and RN nursing service delivery to the Long-Term Care Program).

VON is reimbursed by the Continuing Care Program for its services on the basis of an agreed upon cost per visit. VON's service volume fluctuates over time. These fluctuations are illustrated by data for VON's 1986/87 short term nursing caseload that ranged from 1,533 cases per month to 1,703 cases per month. The number of short-term nursing visits ranged from 5,743 to 6,775 a month in the same period. VON is able to respond to such fluctuations by quite extensive use of part-time staff. This approach has enabled VON to achieve virtually 100% staff utilization and contributes greater efficiency in service delivery.

Table 10

VON HOME CARE ADMISSIONS IN WINNIPEG

DECEMBER 1980 - 1986

Year	VON Admissions	Total Winnipeg Admissions	VON %
1980	269	497	54
1981	295	557	53
1982	339	790	43
1983	298	549	54
1984	308	537	57
1985	386	684	56
1986	405	644	63

Table 11

NEW HOME CARE REFERRALS REPORTED BY VON (AND VON COORDINATED HOSPITALS) IN WINNIPEG

DECEMBER 1980 - 1986

Year	VON Referrals	Total Winnipeg Referrals	VON %
1980	317	497	64
1981	333	557	60
1982	390	558	70
1983	346	549	63
1984	368	537	68
1985	445	684	65
1986	452	644	70

Table 12

MAXIMUM NUMBER OF CASES CARRIED BY VON (AND VON COORDINATING HOSPITALS) IN WINNIPEG

DECEMBER 1980 - 1986

Year	VON Cases	Winnipeg Cases	VON %
1980	1,012	6,821	25
1981	1,194	7,686	24
1982	1,349	8,008	24
1983	1,399	8,518	24
1984	1,489	8,939	23
1985	1,608	9,601	23
1986	1,703	10,444	22

The Office of Continuing Care has not established formal mechanisms to ensure VON accountability regarding program eligibility and maintenance of care delivery standards:

- orientation of hospital referral and coordinating staff is performed by VON;
- case reviews are conducted by VON using VON objectives and functions;
- client record audits are performed by VON staff;
- care classification guidelines are developed by VON; and,
- VON standards are utilized for service delivery.

The Office of Continuing Care has fallen short in carrying out frequent caseload or program reviews of VON services delivery similar to those it conducts in the regions. This inhibits the Continuing Care Program's ability to understand the care management and service practices of VON. Although financial and program information reports are submitted monthly, only highly questionable issues are investigated. Even then the investigations are superficial in nature and the Program accepts plausible explanations.

Furthermore, there is also no clear definition of which VON services are being purchased by the Continuing Care Program. A formal contract does not exist and as a result, Program and Department staff feel limited in the degree to which they are able to exercise control over the operations of the VON.

Further, there is room for improving financial reporting. VON's monthly reports to Administrative services do not distinguish short-term care costs from long-term care costs. Because the Department has failed to institute a service contract with VON, it is in a weaker position to require VON's adherence to the agreed upon service costs.

VON Standards and Philosophy

It generally is understood that VON, Winnipeg is not sympathetic to the utilization of LPNs for direct service work in the community setting. This philosophy of VON stems of the Licensed Practical Nurses Act.

> In this Act, it is stated that "not being a registered nurse or a person in training to be a registered nurse" the LPN "undertakes the care of patients under the direction of a medical practitioner or a registered nurse..."

It is in the interpretation of the word "direction" that VON takes issue (i.e., it is interpreted to mean on-site supervision). Any clients requiring nursing services post hospital discharge automatically receive RN rather than LPN services (at least initially). As long as the client remains within the short-term care system, RN services and not LPN will be utilized.

In addition, there is a seemingly unwritten standard that all clients requiring VON homemaking services are to receive them on a weekly basis. In comparison, the unwritten standard of Continuing Care Program is for biweekly visits. As a result of these nursing and homemaking standards, the per capita costs for VON clients likely will be higher than long-term care clients costs, given similar client needs.

It is in the area of nursing care that there appears to be a lack of congruence between the VON and the Continuing Care Program philosophies of care. The Continuing Care Program guidelines clearly state that:

> "Home Care Services will be provided by persons with the minimum skill required to provide the service."

VON, however, is committed to providing care "of the highest standard". The client survey data suggests this high standard results in over servicing, whereas the minimum skill philosophy of the Program did not adversely affect client perception of the Program.

We noted the view expressed by community Continuing Care staff that the high standards and lengthy service periods of VON create difficulty for clients when they are transferred from short-term to long-term care. Clients become dependent on nursing service and accustomed to VON's high level of homemaking.

OPTIONS

With regard to VON's role in the hospital, all of the VON staff in hospital referral and coordinator positions could be replaced with Continuing Care Program staff. This would allow Continuing Care Program to control the VON and long-term care work flow, and to strengthen their relationship with the Winnipeg hospitals.

The replacement process could be progressive (i.e., over eighteen months) allowing time to orient new staff and establish credibility in the hospital environment. Organizational responsibility for these positions should be located in a single centre such as the Office of Continuing Care or a single Winnipeg region.

If VON is to remain in the hospital positions, the Program must develop criteria for short-term and long-term care decisions and long term care interim care plan development. As well, a mechanism to monitor VON decision making regarding short-term and long-term care must be established.

Regardless of the outcome relating to short-term care administration in Winnipeg, a formal contract renewed annualy ought to be established between the Continuing Care Program and VON that includes a contractual agreement on cost per visit, requirements for regular financial reporting, and service delivery methods.

The Office of Continuing Care should also use the program review process for VON (e.g., caseload review and program review) and with the same frequency as it does with the Regions.

Further, liaison responsibilities should be assigned on both sides (Continuing Care Program and VON) with regular meetings scheduled (quarterly, monthly) to discuss issues of mutual concern.

Exhibit 35

SUMMARY FINDINGS: VON

ISSUES/CONCERNS	IMPLICATIONS	OPTIONS/SOLUTIONS
1. Conflicting role as orderer for short-term services and deliverer of services	. over servicing . client dependency	. have CCP program staff in regional offices administering the short-term program (CCP would have to hire at least 27 new staff to perform this work)
2. Concern about VON Role in hospitals		
. able to influence own work flow through long-term and short-term care decision making	. perception of conflict of interest for VON . some evidence to suggest that long-term clients are inappropriately being classified as short-term . inappropriate categorization would lead to client transfers, service disruption and unnecessary paper work	. replace some or all of VON staff in hospital referral and coordinator positions with CCP staff - organizational responsibility should be located in a single centre (Office of Continuing Care or single Winnipeg Region) This would entail CCP hiring at least 19 additional staff
. VON required to represent CCP to hospital staff	. potential communication impairment between CCP and hospitals . CCP lacks important information regarding emerging hospital trends	. replacement process could be gradual . if VON to remain in hospital, decision and care plan criteria and monitoring mechanism should be established
. VON hospital nurses may lack community health perspective	. potential contribution to client dependency	

Exhibit 35

SUMMARY FINDINGS: VON (cont'd)

ISSUES/CONCERNS	IMPLICATIONS	OPTIONS/SOLUTIONS
	. potential for over emphasis and over servicing with VON services . corresponding potential to under utilize non VON services	
3. Lack of mechanisms to ensure VON accountability to CCP		
. no formal contract	. weak cost control . poor service control by CCP	. formal contract should include contractual agreement on cost per visit
. limited program review process	. limited service control by CCP . inhibits CCP ability to understand care management and service practices of VON	. program review process enforced
. limited information sharing	. misconceptions . inhibits CCP from identifying service trends	. liaison responsibility should be assigned on both sides and regular meetings convened (monthly, quarterly)
4. VON standards and philosophy re Nursing Services leads to reliance on richer service package	. RN used where program guidelines indicate potential for LPN . cost implications . unnecessarily raises client service expectations	. develop understanding and commitment from VON to comply with program guidelines - this should be reflected in the contract . caseload review performed more frequently on-site by CCC

VICTORIAN ORDER OF NURSES - RECOMMENDATIONS

1. THE OFFICE OF CONTINUING CARE SHOULD, IN CONSULTATION WITH THE VON, PLAN FOR THE CONTINUING CARE PROGRAM REGIONAL OFFICES TO ASSUME RESPONSIBILITY FOR CASE MANAGEMENT OF SHORT-TERM CASES IN WINNIPEG. IMPLEMENTATION OF THIS MEASURE SHOULD TAKE PLACE WITHIN 18 MONTHS OF INITIATION OF THE PROCESS. THE PROGRAM WILL HAVE TO HIRE AT LEAST 27 ADDITIONAL STAFF TO CARRY OUT THESE RESPONSIBILITIES, ASSUMING CURRENT SHORT-TERM CASELOADS AND EXISTING CASELOAD STANDARDS.

2. THE VICTORIAN ORDER OF NURSES' STAFF IN WINNIPEG HOSPITALS (REFERRAL NURSES AND CASE COORDINATORS) SHOULD BE REPLACED PROGRESSIVELY BY NURSES REPORTING TO THE CONTINUING CARE PROGRAM. WHERE NUMBERS WARRANT, CONTINUING CARE ALSO SHOULD LOCATE NURSING SUPERVISORS IN THE HOSPITALS. MANAGEMENT RESPONSIBILITY FOR THESE NEW CONTINUING CARE PROGRAM STAFF SHOULD BE GIVEN TO ONE OF THE WINNIPEG REGIONAL OFFICES. THE PROGRAM WILL HAVE TO HIRE AT LEAST 23 ADDITIONAL STAFF TO CARRY OUT THESE RESPONSIBILITIES IN ORDER TO MAINTAIN CURRENT STAFFING LEVELS FOR THESE FUNCTIONS.

3. THE OFFICE OF CONTINUING CARE, IN CONSULTATION WITH VON, SHOULD DEVELOP A CONTRACT TO COVER SERVICES PURCHASED FROM VON UNDER THE PROGRAM AND AN UNDERSTANDING THAT VICTORIAN ORDER OF NURSES WILL DELIVER SERVICES IN A MANNER CONSISTENT WITH PROGRAM POLICIES. IT SHOULD INCLUDE AN AGREED UPON COST PER VISIT. THIS CONTRACT SHOULD BE RENEWED ANNUALLY.

4. THE OFFICE OF CONTINUING CARE AND VON SHOULD EACH ASSIGN RESPONSIBILITY TO INDIVIDUAL STAFF MEMBERS FOR ONGOING LIAISON BETWEEN THE TWO ORGANIZATIONS. THESE INDIVIDUALS SHOULD MEET ON AT LEAST A QUARTERLY BASIS TO DISCUSS MUTUAL CONCERNS.

PART VI RECOMMENDATIONS AND IMPLEMENTATION

INTRODUCTION

In this section of the report, the review recommendations are presented along with a time frame for their completion. Responsibility for each recommendation is also indicated. Exhibit 36, following, outlines this implementation plan.

Exhibit 36

EXTERNAL REVIEW
MANITOBA CONTINUING CARE PROGRAM
RECOMMENDATION IMPLEMENTATION PLAN

RESPONSIBILITY	RECOMMENDATION	ESTIMATED TIME FRAME FOR COMPLETION (IN MONTHS)					
		1	3	6	9	12	18
	PROGRAM POLICIES AND DIRECTION						
Office of Continuing Care/MHSC/Hospitals	1. In consultation with MHSC and with individual hospitals, the Office of Continuing Care should review the need for community-based hospital replacement services (i.e., services provided on an in-home basis that offer a substitute for hospital in-patient care) and determine whether the Continuing Care Program should assume responsibility for such services.			*			
Department of Health	2. The DEPARTMENT should adopt an expanded long-term strategy to facilitate the development of independent not-for-profit cleaning services in all communities (where geographically feasible) across the province. This effectively should take the Program out of the business of providing housecleaning services. Consideration also should be given to including house maintenance services along with independent not-for-profit cleaning services.		*				
Government of Manitoba	3. The Government should prepare legislation for the Continuing Care Program that defines the purpose, scope and mandate of the Program.				*		

Exhibit 36

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RESPONSIBILITY	RECOMMENDATION	ESTIMATED TIME FRAME FOR COMPLETION (IN MONTHS)					
		1	3	6	9	12	18
	PROGRAM SCOPE AND MANDATE						
Community Health Services Division	1. The DEPARTMENT should examine the findings and recommendation of previous studies and task forces on services for the adult disabled. It should select and implement an appropriate administrative structure and delivery model to serve this population. It is recommended that home care services for the adult disabled continue to be administered through the Continuing Care Program.		*				
Office of Continuing Care	2. The OCC should review program objectives with a view to placing greater emphasis on achieving client independence. Efforts should be undertaken to sensitize case coordinators to this concern.		*				

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RESPONSIBILITY	RECOMMENDATION	ESTIMATED TIME FRAME FOR COMPLETION (IN MONTHS)					
		1	3	6	9	12	18
	PROGRAM EFFECTIVENESS						
Office of Continuing Care	1. The Office of Continuing Care should reexamine the program's objectives with a view to ensuring that they fully represent what the program is intended to accomplish. Having established appropriate program objectives, the Office of Continuing Care should introduce mechanisms to monitor their achievement. The Department should approach the Alberta Department of Community Health with a view to adopting measures that they have recently developed for the home care outcome measurement tool.			*			
Office of Continuing Care	2. The Office of Continuing Care should develop a comprehensive quality assurance (QA) program. Overall responsibility for the quality assurance program should be located in the Office of Continuing Care.					*	

Exhibit 36

EXTERNAL REVIEW
MANITOBA CONTINUING CARE PROGRAM
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RESPONSIBILITY	RECOMMENDATION	ESTIMATED TIME FRAME FOR COMPLETION (IN MONTHS)					
		1	3	6	9	12	18
	INFORMATION SYSTEMS						
MHSC Information Services Division	1. The Information Services Division 1988/89 development budget for the Home Care Payroll system re-write, community services and Continuing Care projects should be approved. No further budgetary erosion in this division should be permitted.	*					
Department of Health	2. The DEPARTMENT should give priority to the completion of a long-term care strategic data plan. This plan should be completed as soon as possible.		*				
MHSC Information Services Division	3. The Information Services Division should give immediate priority to developing a data strategy that will address the integrated Home Care Payroll, Continuing Care and Community Services Project.	*					
MHSC Information Services Division	4. The Information Services Division should enhance its information centre with a dedicated data specialist who will concentrate on the short-term information needs of Continuing Care. In the longer-term, the Division should examine the approaches used in other government health and human service environments for the staffing and operation of information centres with the view to creating a model appropriate to Manitoba		*				
MHSC Information Services Division	5. The Alberta Coordinated Home Care information system should be obtained as an interim solution. Close collaboration with both Alberta and Saskatchewan in future home care systems development should be pursued. Opportunities for shortened development times and reduced costs exist in such collaboration. It makes little sense for three western provinces to duplicate efforts and costs in this area when there is an expressed willingness to share and collaborate.		*				

Exhibit 36

EXTERNAL REVIEW
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RESPONSIBILITY	RECOMMENDATION	ESTIMATED TIME FRAME FOR COMPLETION (IN MONTHS)					
	BUDGETARY CONTROL	1	3	6	9	12	18
The Department of Health	1. The DEPARTMENT should develop regional program budgets for Regional Continuing Care that comprise operating/staff and home care assistance spending. These budgets should be managed by regional staff reporting to the Regional Directors. OCC should be consulted in the preparation, approval and ongoing management of these budgets. Such consultation should be facilitated by mechanisms to ensure OCC information needs and concerns regarding regional operations are taken into consideration (e.g., emerging health needs, changes in technology, province-wide policy initiatives).					*	
The Department of Health	2. The program should require regional program managers to manage their budgets more actively and to stay within approved levels and should give program staff greater discretion over service levels per client (i.e., permitting dilution of services) in order to achieve budget targets.					*	
The Department of Health	3. The program should give consideration to introducing measures that would serve to encourage clients to meet their needs through their own resources (e.g., user fees, waiting periods prior to receiving non-professional services, user fees during the initial period of service, limiting hours in which services are provided).					*	

Exhibit 36

Exhibit 36

EXTERNAL REVIEW
MANITOBA CONTINUING CARE PROGRAM
RECOMMENDATION IMPLEMENTATION PLAN

RESPONSIBILITY	RECOMMENDATION	ESTIMATED TIME FRAME FOR COMPLETION (IN MONTHS)					
	FORECASTING DEMAND AND PROGRAM PLANNING	1	3	6	9	12	18
Office of Continuing Care	1. The OCC should develop a practical, robust method for forecasting service growth and taking account of emerging service trends. This method should be used consistently across all regions.			*			
Office of Continuing Care	2. A formal planning function should be established in OCC. It should entail the appointment of a program planning officer. Specific responsibilities will include organizing planning sessions with RCCC, liaison with MHSC, development and analysis of planning data bases.				*		

Exhibit 36

EXTERNAL REVIEW
MANITOBA CONTINUING CARE PROGRAM
RECOMMENDATION IMPLEMENTATION PLAN

RESPONSIBILITY	RECOMMENDATION	ESTIMATED TIME FRAME FOR COMPLETION (IN MONTHS)					
		1	3	6	9	12	18
	MANAGEMENT ACCOUNTABILITY						
Department of Health	1. The DEPARTMENT should establish a financial function for each region. It should assume responsibility for financial planning and reporting, management of financial reporting systems, contract administration, and financial controls.					*	
Department of Health	2. The DEPARTMENT should undertake to train existing regional managers in financial administration. Competence in financial administration should be made a requirement for new appointments to regional financial positions.					*	

Exhibit 36

EXTERNAL REVIEW
MANITOBA CONTINUING CARE PROGRAM
RECOMMENDATION IMPLEMENTATION PLAN

RESPONSIBILITY	RECOMMENDATION	ESTIMATED TIME FRAME FOR COMPLETION (IN MONTHS)					
		1	3	6	9	12	18
	STAFF TRAINING						
Department of Health	1. The program should develop and undertake training programs to enhance the following areas: . program planning and evaluation skills among CCC, and regional program staff . assessment skills among non-baccalaureate case coordinators				*		
Department of Health (Community Services Division)	2. Measures should be taken to ensure that resources allocated for inservice training are not sacrificed as a result of budget pressures.		*				

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EXTERNAL REVIEW
MANITOBA CONTINUING CARE PROGRAM
RECOMMENDATION IMPLEMENTATION PLAN

RESPONSIBILITY	RECOMMENDATION	ESTIMATED TIME FRAME FOR COMPLETION (IN MONTHS)					
		1	3	6	9	12	18
	SERVICE COORDINATION						
Hospitals/Regional Offices	1. Regional offices should assign responsibilities to specific case coordinators for coordinating discharges at each hospital. Hospitals should each assign responsibility to a specific staff member for coordinating with the Continuing Care Program. In many instances this individual could be the hospital discharge planner.		*				
Hospitals/Regional Offices	2. Both the CCP and hospital individuals involved in coordination should provide orientation and ongoing information sessions to hospital staff.		*				
Office of Continuing Care	3. The OCC should continue to undertake program and caseload reviews and should place special emphasis on ensuring that eligibility criteria and service definitions are consistent with program policies across all regions. In addition, the program should reinstate the annual program review process in each region.			*			
Office of Continuing Care/Regional Offices	4. The OCC and RCCC should be responsible for identifying emerging service issues and ensuring swift program policy decisions in response.			*			

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EXTERNAL REVIEW
MANITOBA CONTINUING CARE PROGRAM
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RESPONSIBILTY	RECOMMENDATION	ESTIMATED TIME FRAME FOR COMPLETION (IN MONTHS)					
		1	3	6	9	12	18
	SERVICE DELIVERY						
Office of Continuing Care	1. The program should establish minimal organizational requirements. . The RCCC positions should be full time and individuals holding these positions should not be given other significant responsibilities such as area management roles. . In regional organizational structures, CCP staff should report to supervisors in the CCP. . Each region should be responsible for assigning resource development responsibilities to appropriate program staff. Compliance with these organizational requirements should be monitored through the program review process.				*		
Regional Office	2. Staff should be appointed in each region to supervise case coordinators. These responsibilities should not be given to the RCCC. There should be at least one supervisor for every 8 case coordinators. In some regions this will require additional staffing resources.			*			

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RESPONSIBILITY	RECOMMENDATION	ESTIMATED TIME FRAME FOR COMPLETION (IN MONTHS)					
		1	3	6	9	12	18
Office of Continuing Care	3. Caseload review should be used to monitor Case Coordinator service delivery decisions and any short-comings in supervision. Further, assessment charting standards should be developed and assessment chart audits regularly incorporated in the caseload review process.	*					
Office of Continuing Care	4. A written pamphlet outlining the client appeal process should be prepared. It should be made available to program staff and distributed to all clients on admissions. Clients should sign a form indicating awareness of the process. At the time of reassessment or at service change, clients should be advised again of the appeal process. The OCC should establish a mechanism to monitor client awareness of appeal procedures. This could entail an annual audit involving telephone interviews with a small sample of clients.			*			
Office of Continuing Care	5. The OCC should eliminate the responsibilities for case coordinators regarding provision of direct service (e.g., counselling/teaching). The results of this change should be taken into account in identifying staff year requirements.		*				

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MANITOBA CONTINUING CARE PROGRAM
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RESPONSIBILITY	RECOMMENDATION	ESTIMATED TIME FRAME FOR COMPLETION (IN MONTHS)					
	INTAKE/ASSESSMENT/PANELLING	1	3	6	9	12	18
Office of Continuing Care/Regional Office	1. Pre-assessment screening should be introduced in all regions. This screening should be performed by professional staff. The program should also develop a mechanism to flag selected cases who are screened out from assessment. These cases should be followed up to ensure their needs have been met.			*			
Office of Continuing Care	2. The OCC should terminate the joint (social worker and nurse) assessment process and should develop criteria to identify instances where a consultation from a case coordinator of another discipline is indicated.			*			
Office of Continuing Care	3. The program should identify panel membership requirements. These should be applied consistently across all regions.		*				
Office of Continuing Care	4. Further guidelines should be developed regarding required formats for case preparation and panel presentations. Such guidelines would specify required content in prepared case material and areas to be covered in panel presentations.			*			
Office of Continuing Care	5. The OCC should develop mechanisms to monitor the appropriate use of the panel process including a documentation audit of prepared case material and panel decisions and an on-site panel review process by OCC staff. (This process would parallel the caseload review process).			*			

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EXTERNAL REVIEW
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RESPONSIBILITY	RECOMMENDATION	ESTIMATED TIME FRAME FOR COMPLETION (IN MONTHS)					
		1	3	6	9	12	18
	STAFF WORKLOADS						
Office of Continuing Care	1. OCC should commission a project to: a) identify and review existing tools for use in managing case coordinator and resource coordinator workloads; and b) develop, test and compare province-wide workload measurement tools for case coordinators and resource coordinators respectively.		*				
Department of Health	2. Until new workload measurement methods are developed and applied, the DEPARTMENT should adopt interim measures to staff to the current workload standards. To avoid any commitments that will not be supported by future standards, additional staff should be hired on a term basis	*					

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RESPONSIBILITY	RECOMMENDATION	ESTIMATED TIME FRAME FOR COMPLETION (IN MONTHS)					
		1	3	6	9	12	18
	DIRECT SERVICE WORKERS						
Office of Continuing Care	1. The Department should continue to provide the Home Care Attendant/Home Support Worker Course through Red River College. This course should be expanded to include emergency training (e.g., cardio pulmonary resuscitation and emergency first aid) and be available to all workers in the program.		*				
Office of Continuing Care	2. Regional offices should develop and make accessible to direct service workers a local policy and procedure manual addressing client care practices. This manual should be updated regularly.		*				
Office of Continuing Care	3. Each regional office should develop and implement a formal orientation program for all direct service workers. This program should include, as a minimum, an overview of the Continuing Care Program's goal and objectives, local policy and procedure information, emergency protocols, as well as an introduction to office and program staff. This responsibility should be delegated to the Resource Developer. Direct service workers should not receive client assignments until they have completed the orientation process.	*					
Office of Continuing Care	4. Regional offices, in consultation with the Office of Continuing Care, should plan and implement a continuing education program for all direct service workers ensuring that knowledge and skills are maintained and updated (including regular cardio pulmonary resuscitation certification and emergency first aid updates). The Office of Continuing Care should ensure the Program Resource Specialist oversees this process.		*				

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RESPONSIBILITY	RECOMMENDATION	ESTIMATED TIME FRAME FOR COMPLETION (IN MONTHS)					
		1	3	6	9	12	18
Office of Continuing Care	5. All work instructions to direct service workers must be in writing, providing sufficient client information to ensure safe, appropriate care. Work clarification questions should be directed to the Resource Coordinator who, in turn, should contact the Case Coordinator for further clarification if needed.	*					
Office of Continuing Care	6. Direct service workers, when appropriate, should be involved in client case conferences.	*					
Office of Continuing Care	7. Regional offices should ensure that all direct service workers receive regular in-person feedback on their performance. A formal performance appraisal should be conducted on an annual basis.						
Office of Continuing Care	8. Regional offices should assign Program staff to deal with direct service workers' questions/dilemmas after working hours and on the weekends. The direct service workers should be informed, in advance, of whom to contact after hours.	*					

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MANITOBA CONTINUING CARE PROGRAM
RECOMMENDATION IMPLEMENTATION PLAN

RESPONSIBILITY	RECOMMENDATION	ESTIMATED TIME FRAME FOR COMPLETION (IN MONTHS)					
		1	3	6	9	12	18
	CLIENT SERVICES						
Office of Continuing Care	1. The OCC should review the policy regarding self-care patients in relation to the provision of supplies. A solution should be sought which motivates clients to assume self-care		*				
Office of Continuing Care	2. The OCC should use caseload review data to identify gaps in community resources across the province and subsequently should assess the relative cost effectiveness of two alternative strategies: . continue to have the OCC purchase services in specific communities . concentrate efforts on developing independent service resources (e.g., Meals on Wheels)			*			
The Department of Health (Community Health Services Division)	3. The DEPARTMENT should explore providing additional incentives to recruit professionals to the Northern and remote areas of the province.		*				
Office of Continuing Care	4. The OCC should clarify that the service level limits do not take into account the costs of the full range of community services. (Specifically, they do not include case management, day care, respite care, community therapy services, supplies, equipment).	*					

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EXTERNAL REVIEW
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RESPONSIBILITY	RECOMMENDATION	ESTIMATED TIME FRAME FOR COMPLETION (IN MONTHS)					
	VICTORIAN ORDER OF NURSES (VON)	1	3	6	9	12	18
Office of Continuing Care/Regional Office	1. The Office of Continuing Care should, in cosultation with the VON, plan for the Continuing Care Program regional offices to assume responsibility for case management of short-term cases in Winnipeg. Implementation of this measure should take place within 18 months of initiation of the process. The program will have to hire at least 27 additional staff to carry out these responsibilities, assuming current short-term caseloads and existing caseload standards.						*
Office of Continuing Care/Regional Office	2. The Victorian Order of Nurses' staff in Winnipeg hospitals (referral nurses and case coordinators) should be replaced progressively by nurses reporting to the Continuing Care Program. Where numbers warrant, Continuing Care also should locate nursing supervisors in the hospitals. Management responsibility for these new Continuing Care Program staff should be given to one of the Winnipeg Regional Offices. The Program will have to hire at least 23 additional staff to carry out these responsibilities in order to maintain current staffing levels for these functions.						*
Office of Continuing Care/Victorian Order Of Nurses	3. The Office of Continuing Care, in consultation with VON, should develop a contract to cover services purchased from VON under the program and an understanding that Victorian Order of Nurses will deliver services in a manner consistent with program policies. It should include an agreed upon cost per visit. This contract should be renewed annually.			*			
Office of Continuing Care/Victorian Order Of Nurses	4. The Office of Continuing Care and VON should each assign responsibility to individual staff members for ongoing liaison between the two organizations. These individuals should meet on at least a quarterly basis to discuss mutual concerns.		* * *				

ADDENDUM

CONTINUING CARE PROGRAM:
LESSONS FROM EXPERIENCES IN OTHER JURISDICTIONS

(KANE AND KANE)

CONTINUING CARE PROGRAM:

LESSONS FROM EXPERIENCES IN OTHER JURISDICTIONS

Submitted by Robert L. Kane and Rosalie A. Kane
University of Minnesota School of Public Health

INTRODUCTION

This report comments on features of Manitoba's Continuing Care Program, now twelve years into its full-scale operation. Our review is designed as background to an external review of the Continuing Care Program presently being conducted by Price Waterhouse in Toronto. We are guided in our task by the same six terms of reference set forth for the overall external review. To paraphrase and abbreviate the list, this background paper comments on (1) the level and mix of services provided by the Continuing Care Program; (2) the utilization and cost of services; (3) the relationships between the personal care home and acute-care sectors and the Continuing Care Program; (4) the potential role of the Continuing Care Program toward special populations in need (particularly the psychiatrically ill and the physically disabled); (5) the desirability of capping home care expenditures as opposed to retaining open-ended funding; and (6) future policy directions.

We approach each of these questions by consulting available literature and research about long-term care outside Manitoba--particularly in the United States, but also, to some extent, in other jurisdictions in Canada, and abroad. Even without referring to particulars about Manitoba, it is possible and useful to consider what, if anything, accumulated experience elsewhere tells us about programs established to meet the needs of the frail elderly and functionally impaired in their own homes. In so doing, we have relied heavily on a major synthesis of research on long-term care that we recently completed (Kane & Kane, 1987); for that book, we analyzed voluminous published and unpublished material that shed light on the effects of long-term care programs in the

United States, both in the community and in institutions. Our baseline for understanding Manitoba's Continuing Care Program is the quantitative and qualitative case-study we conducted between 1982-1984 on long-term care in Manitoba, British Columbia, and Ontario (Kane & Kane, 1985), supplemented by summaries of more recent program statistics and program policies.

Our earlier study of Manitoba and the other two Canadian provinces was stimulated by a desire to generate lessons for the United States, where the idea of universal long-term care benefits such as the insured personal care home benefit and the universally available continuing care benefit were considered too costly for a country already concerned about the high costs of its means-tested, "spend-down" programs. Our study in Canada confirmed that universal long-term care benefits were not only a humane and equitable public policy (compared to the financial hardships that fall on families needing long-term care in the United States), but also that universal long-term care benefits with governments as major purchasers of service can lead to high quality care at lower total costs.

Thus, as a result of our previous work, we regard Manitoba's programs, including the Continuing Care Program, as positive models of long-term care. In our view, Manitoba illustrates one of the best long-term care systems in North America. It seems ironical to turn to the United States, where long-term care systems are much less-developed and coherent to provide guideposts for Manitoba. We can usefully draw such examples, however, because of the richness of research and evaluation in the United States, the wealth of well-studied demonstration projects (which cynics might view as inexpensive substitutes for established public benefits), and the advances in information technology. Lessons drawn from the United States can provide both cautionary tales (describing what has not worked and what has gone wrong) and positive examples of directions that might be taken to strengthen Manitoba's program and increase its fiscal accountability without sacrificing its principles of universality and its other many advantages.

Therefore, at the outset, we describe a set of general goals or attributes of an effective long-term care system. We can then use these as yardsticks against which to examine progress in Manitoba. The same set of goals can also be used as a framework to identify developments in other jurisdictions that have constructively worked toward various elements of an ideally effective system.

MANITOBA MEASURED AGAINST IDEAL CRITERIA

Criteria for an Effective Long-Term Care System

Elsewhere (Kane & Kane, 1987) we have identified a set of criteria for effective delivery of long-term care, which we present now as a framework for the present discussion. We take as axioms that a long-term care system should have the following characteristics:

- It should be geared toward functional impairments, with services allocated to correspond to functional needs.

- It should be organized so that treatable problems causing dysfunction are likely to be identified and treated -- this requires appropriate communication with primary health care and hospital care providers.

- It should offer a considerable range of services in both the community and in facilities.
- It should permit as much choice as possible to those who require service, and both the community-based and home-based services

should be in forms that are positively valued by their clientele.

- Its component services should be of acceptable quality, with all provider incentives directed toward maintaining and improving that quality.

- It should be visible to potential users and to those who wish to make referrals. Entry into the system should be uncomplicated.

- It should be equitable in serving those with functional needs, and therefore, be based on accurate periodic measures of functional ability.

- It should bolster, but not inappropriately replace family care. However, recognizing that families will continue to give a large amount of long-term care service, the long-term care system should be equitable across generations and from family to family; that is, its demands on family members who give care should be fair, no family member should be expected to undertake too disproportionate an obligation, and the system should be just both in the way it treats clients with families and clients without, and also in the way it treats families.

- It should be characterized by clear communications among organizations financing and/or providing services; here, we include the importance of coordination between acute and chronic care; between home care and nursing home care; among health services, social services, and mental health services; and among federal, provincial/state, and local governments.
- It should be accountable to the public for quality and accessibility of all services and for all costs, both public and

private.

. Both public and private costs should be no greater than necessary to accomplish the goals. Here we emphasize the importance of looking at all costs; simply transferring costs from one purse to the other will not suffice.

Continuing Care Program and LTC in Manitoba

Manitoba's Continuing Care Program forms a central part of a system of long-term -- other major components are the personal care home program, and hospital-based geriatric assessment and extended care. In general, long-term care in Manitoba gets high points according to the criteria outlined. Table 1 summarizes the appraisal of the program for each of the major criteria.

Access to Manitoba's long-term care system is based firmly on functional need without regard to income or age. The assessment process is relatively simple and unbureaucratic. A standard assessment tool is used province-wide. The primary considerations are needs for assistance, availability of informal support, and client preferences. The decision about the client's functional needs is made independently of the decision about where the care should take place. Functional capacity is, thus, a primary determinant of service provision.

The application of this standard assessment and the principles applied to care planning promise equity both across clients and between the generations. Family burdens are negotiated and considered in development of care plans.

The Continuing Care Program serves as a major entry point for clients. The program is accessible by a variety of mechanisms, including direct access by clients or their families. This elimination of a requirement for professional referral as a mandatory conduit for information and for service is an important aspect of the program. In too many situations, professionals who should know about community services are ill-informed and sometimes even indifferent.

Long-term care benefits keyed to functional disability are highly desirable, with one proviso: the system must be able to detect and eliminate remediable causes of functional impairment. Providing services to compensate for impairments that could be eliminated in the first place is neither humane nor cost-effective. On this point, we doubt that Manitoba has yet achieved optimum communication and working arrangements between case coordinators and the primary care physicians (or geriatricians, when available), or optimum links between the acute-care hospital and chronic care either in the community or in a facility. The paneling procedure, which is mandatory for all applicants into personal care homes, provides a useful structure for oversight of the case coordinators' decisions and permits a fuller medical assessment before major relocations. Thus, the panelling process is a commendable feature of Manitoba's program, consistent with the current effort of many states in the United States to launch mandatory pre-admission screening prior to entry into nursing homes. Unless watched carefully, however, a panelling process can become perfunctory. Moreover, it may sometimes occur too late to make a medical evaluation maximally beneficial. It certainly does not substitute for an evaluation of the accuracy of case coordinators' decisions, especially those that are never panelled.

Although there are no easily identified studies about the reliability or validity of Manitoba's assessment process, there is reasonable basis for assuming that the initial assessments are generally well done. (The program has established a way to prioritize scarce services on the basis of three risk categories; it would be interesting to examine the inter-assessor reliability on those summary judgments, and also their validity in terms of later client outcomes.) A thoroughgoing evaluation of the assessment process would require careful study of how well clients fare over time. For example, how many need to change their level of support? How many enter personal care homes on an unplanned basis soon after enrollment in community care? The current data system does not make such exploration easy, but special studies using samples from the caseload are surely feasible. Such studies have not generally been reported anywhere.

Experts on assessment have come to distinguish between representing multi-disciplinary perspectives in the design of instruments and service structures, and multi-disciplinary participation in the assessments themselves. There is growing appreciation of the potential for redundancy in the collection of client data. In the case of the care coordinators, the assessment may not need the attention of both a social worker and a nurse. The assessment form could represent the insights of both disciplines, yet rely on only one person to do the initial assessment except in unusual circumstances. If special problems are noted, other relevant groups can then be brought in. When feasible, a multi-disciplinary mix of case managers will also help ensure that the program itself is enriched by multiple perspectives.

A wide range of long-term care services are available in Manitoba, and seemingly the province has been able to develop and retain a cadre of personal care workers and homemakers. The Continuing Care Program's care managers are responsible for initial allocation of a wide range of services, including not only the care the program subsidizes directly but also adult day care, medical equipment, and, most important, admission to personal care homes. Once a client is admitted to a nursing home, however, the case coordination ceases, and case coordinators' responsibility for clients ends. This may be contrasted to the program in British Columbia where the same case managers purchase and monitor care and adjust the levels of care even when the client is in a facility. In theory, this division of responsibility has a disadvantage because one program can adjust its costs and case-mix at the expense of another.

Our studies of the delivery of health and social services over the course of many years suggest to us that every system must have points of organizational division, and that the plans for coordination at these junctures are important. In the United States, there has for a long time been poor coordination between health and social services generally. In Manitoba, health and social services of many types are linked organizationally at the regional offices -- a situation we view as a strength. But within the Continuing Care Program itself, there are articulation points that may need attention, particularly the relationship between the short-term home care program (which in Winnipeg is under the auspices of the Victorian Order of Nurses) and the long-term home care program.

The relationship between the Continuing Care Program and the insured services of the Health Services Commission merit particular attention. The Continuing Care Program was deliberately established as a separate entity from the Commission, in keeping with the fact that its services transcend health care and need to be well linked to other services at the local level. But the separation can become dysfunctional at times. For example, although the Continuing Care Program is the point of entry for institutional care, the oversight for the care rests elsewhere. Also, the planning and budgeting for these two aspects of long-term care are quite independent. Yet at some point, home care and personal-care-home care must be considered as a total package because they represent the allocation of resources to persons with functional impairment. The Manitoba situation differs from that in other provinces where similar programs have been developed. In British Columbia, for example, although the community care and institutional care are budgeted differently, they are part of the same ministry. In Manitoba, the Commission's separate status from the ministry makes this coordination of planning and budgeting more complicated. At a very basic level, it would be useful for planning and evaluation to integrate information about the use of personal care homes and hospitals with the use of home care on the client level, something that is currently very difficult (although it has been done in Manitoba in a research context). Such information would make accountability in the system more possible.

This organizational situation cannot be compared readily to anything in the United States because there the funding is so fragmented. A major stumbling block in the United States is the heavy reliance on welfare funding (that is, funding available only to the poor) for most of government supported long-term care. Thus, in the United States, few programs can readily combine home nursing (a health service which, at least for the old, is universal) and homemaker services (which are means-tested). The exception is in special demonstration projects that have used pooled funds or even have organized the full gamut of services under a single capitated system. (Many of these projects are also restricted to those whose incomes would qualify them for the means-tested Medicaid program.) In the United States, most demonstration projects that merged funding sources for community care for the functionally impaired used a form of case management to allocate services, as does Manitoba. Like Manitoba, the case managers tend not to have authority once the clients enter a nursing home.

The case managers in demonstration community-care programs in the United States have been held accountable for the costs generated by each client, with the programs operating under per-program and per-case caps on expenditures. In Manitoba, it appears that per-case caps also exist (for example case coordinators are not allowed to authorize per-client expenditures that exceed personal care home costs at the same level of care without prior authorization of the exception). However, issues also arise about which expenditures will count toward the cap. It seems that in Manitoba, for example, a variety of programs (e.g., adult day care, durable medical equipment, and even the cost of case management itself) does not get calculated into the costs of community care. Also the program funding appears to be open-ended.

Our ideal criteria include indications that the care and its outcomes are of adequate quality. From the materials available to us, it seems that the quality assurance mechanisms in Manitoba, particularly in the Continuing Care sector, are rather rudimentary; indeed, the data generated in the case and program reports do not permit an effective surveillance. Quality assurance in home care tends in general to be under-developed in other jurisdictions as well though it is an area presently coming under scrutiny. Manitoba does have the advantage that its scale of operation (given a provincial population that barely exceeds one million) permits program officials to have considerable personal knowledge of the professional and bureaucratic actors; the program is characterized by better will than in the United States where adversarial relationships between providers and payers, and across levels of government often arise.

To summarize, Manitoba's long-term care provisions rate well compared to those in other jurisdictions, particularly in the United States. The Continuing Care Program, as gateway to the long-term care system and as deliverer or funder of most of the home-based services is to be commended for its program philosophy, the centrality of functional assessment and case management, the range of services, the respect for consumer preference, the visibility of the program, and the easy client access. Areas for possible further attention (discussed later in the report) are the articulation with various parts of the acute-care delivery system, the development of quality assurance and of a more useful management information system, and the development of greater accountability of individual case coordinators and of the continuing care program units for the costs and outcomes of their services.

The "Alternatives" Mentality in the United States

We cannot extrapolate lessons from jurisdictions in the United States to Manitoba without alluding to the theme of home-based services as "alternatives" to nursing-homes. In the United States, publicly-funded home care has tended to be tested by its ability to replace nursing home care; this focus accounts for the type of data collected in several generations of demonstration projects that have been launched beginning in the late 1960s (Weissert, Cready, & Palawek, in press; Applebaum, Harrigan, & Kemper, 1986; Kane & Kane, 1987), culminating in the just-completed National Channeling Demonstration (Kemper, Braun, Carcagno, et al., 1986), which tested the cost-effectiveness of case-managed home care in 10 states. The goal of Manitoba's Continuing Care Program, fortunately, is cast in different terms -- that is, it strives to serve people at high risks for needing care. The dollar limits allowed for any client's plan, however, is ordinarily based on the costs of caring for someone with that level of disability in a personal care home. In that sense, the experience in other jurisdictions that have attempted to deliver home care with similar per-case caps keyed to nursing home costs is relevant.

In general, health care services have tended to be labelled on the basis of where they are delivered. Thus we refer to a set of services as "hospital care", "nursing home care", "home care", and so on. Experience has not taught us that these labels are misleading. As technology changes, we can deliver a wider variety of services that only a few years ago were thought to require an intensive hospital stay are now delivered in an ambulatory setting. Similarly, some patients usually cared for in hospital can be treated at home. Some cared for in nursing homes can likewise be managed at home. A critical determinant seems to be the availability of committed family and the patient's desire to remain in the community.

The official enthusiasm for community care in lieu of institutional care can be traced to the massive efforts in the early 1960s to move patients out of mental health institutions into community care. The current problems of large numbers of under-treated mental patients paints a vivid lesson for those evidencing unbridled enthusiasm for an active policy of community care.

The recognition that much care of the chronically ill previously given in institutions could be given in the community led to an outpouring of effort, especially in the United States, for seeking alternatives to nursing home care. The major motivation was cost. There persisted a strong belief that care in the community was cheaper because it saved the "hotel" costs. Study after study was launched to establish the validity of this belief. Although the studies range geographically to every corner of the United States and vary in their details (program auspice, type of intervention, selection of clientele), there was impressive consistency in the findings: many patients could be managed in the community but doing so did not produce a cost-effective alterative to nursing home care. Especially when the housing and food costs were considered, community care was often more expensive. Extrapolating from at least two decades of demonstration projects in the United States, the following generalizations can be made about home care as an alternative to institutional care:

- Although community care may be less expensive than institutional care for many clients, for some very disabled clients the costs will be more, particularly when the costs of the case management are included. There is a breakeven point at which costs of home care will equal or exceed costs of nursing home care for the same person.

- That breakeven point is not an absolute figure, but varies from region to region. It depends on (a) the disability level and, therefore, the needs of the particular client; (b) the amount of help financed from personal resources, including labour of family; and (c) the actual prices of both services at home and services in facilities, both of which are controlled by public policy.

- In many states in the United States, the public reimbursement rates for institutional care are set quite low. Comparisons may thus be anchored by a standard of nursing home care that is far less than ideal.

- In many jurisdictions, the orthodox notions of community-care involve high levels of service from highly credentialled professionals. Case managers can prolong the time that the break-even point is reached by parsimonious care plans.

- Even when care plans on a case-by-case basis are cost-effective compared to nursing home care, a home care program will fail to be a cost-effective alternative unless most clients served at home otherwise would have entered a nursing home. In the United States at least, entering a nursing home is an undesirable last resort in the minds of both prospective residents and their family members.

- Demonstration projects in the United States eventually became proficient at targeting a clientele that was functionally impaired and had a high level of need for assistance. In randomized trials of community care conducted in the late 1970s and early 1980s, however, it was found that the randomly selected control groups entered nursing homes at a low rate. High mortality rates and impairment levels proved that the targeting had reached a group that was sick, but apparently it had not reached a group that otherwise would have entered nursing homes at a high rate.

These findings do not mean that community care is not a worthwhile goal. Rather, they suggest that community care should be pursued as an end in itself when it is the mode preferred by the citizenry. The lessons of the United States demonstration projects come in the form of cautionary notes. They show the fallacy of evaluating the Continuing Care Program by its overall cost-effectiveness as a substitute for care in personal care homes; this could only be achieved by limiting home care to persons willing to enter a nursing home -- an absurd criterion. On the other hand, the demonstrations suggest that the relative costs of home care compared to nursing home care can be manipulated deliberately by public policy, and the absolute costs of home care can be manipulated by case managers. At times, case managers unconsciously increased costs through an over-protective or too highly professionalised approach, or through applications of orthodox thinking. Some of the insistence on multidisciplinary teamwork may also be a costly bow to collegiality (that also increased the cost of services) rather than a necessary ingredient. The demonstrations also highlight the importance of scrutinizing all the subtle incentives that influence the way services are ordered.

A related issue in interpreting findings about long-term care from other jurisdictions is taking account of changes in the hospital sector. In some respects long-term care is the fallout of policies for acute-hospital care. Many long-term care clients first enter the long-term care system from hospitals. Changing pressures on the hospital will exert strong pressures that reverberate in the long-term care sector. For example, the failure to show a complementary reduction in nursing home use with the introduction of community care cannot merely be interpreted as a failure of the latter. In the United States, the absence of strong regulatory pressure to close nursing home beds or otherwise restrict supply made decreased utilization unlikely. And from the perspective of the costs of hospital care, earlier discharge to a nursing home seemed like a cost-effective outcome. Although there is some level of nursing-home-bed supply that exceeds the potential use and leads to decreased occupancy rates, most areas are still below the threshold. It is only within the last five years that a number of states in the United States have placed to moratoria on construction of nursing homes. Meanwhile, developments in the acute-care sector, including the prospective payment of hospitals stays according to DRGs (diagnosis-related groups) implemented in 1985 have introduced a strong incentive for "quicker, sicker" discharges from hospitals, creating new incentives for use of long-term care. It has become all the more important not to regard a nursing home admission as final lest that become a self-fulfilling prophecy in the light of the need for phased-down post-acute care after hospital discharge.

We now turn to the six questions that were set forth in the terms of reference for the external review of the Continuing Care Program. We address each in terms of information available from other jurisdictions.

QUESTION 1: MIX AND LEVELS OF SERVICE

We interpret this question to be asking in general about the appropriateness of the services given by the Manitoba Continuing Care Program. This question could be specified in a number of ways:

- the appropriateness of the amount of service given to the clientele with differing disability levels or family situations (amount would probably be measured in visits for nursing and hours for other care);

- the appropriateness of the actual mix of services given (i.e., home nursing, homemaking/home attendants, day care), and within home care generally, the appropriateness of the actual plans;

- the appropriateness of the targeting to persons at risk.

Putting it another way, we can ask about the appropriateness of what is done (the actual tasks and services), who does it (the discipline and degree of professional preparation), and how intensively it is done (number of visits, hours of care).

Although beyond the scope of our portion of the external review, we note that these questions cannot be directly answered for the Continuing Care Program from existing data. One cannot readily link information about client disability and other characteristics to actual services received or outcomes. It is also difficult to get full information about the intensity of service any client received over a period of time because of the bifurcation of information about short-term home care versus long-term home care; the difficulty of combining VON data with other program data; and the difficulty of ascribing the time of the case coordinators.

Thus, we can address this question only generally from our interpretation of what is known about appropriate mix and intensity of service. Moreover, the appropriateness of the mix and level of service must be keyed to the program goals. Home-based services can be designed to substitute for nursing homes, to substitute for hospital care, to more generally provide a needed service, and/or to relieve family providers (either for humane reasons or to prolong their care-giving period). One cannot design evaluations without considering the program goals and analyzing results for subgroups accordingly. For example, the admission into a personal care home of a person with advanced Alzheimer's disease will be regarded differently depending on the program's philosophy.

Lessons from other jurisdictions about this question are necessarily general. It can be asserted, however, that home-based services are most valuable and most highly valued to clients if they are flexible, available in evening and weekend hours, provide a solid base of domestic services, and leave the client with a perception of control. Experiences in the United States have been counter-intuitive: instead of a groundswell of utilization of cautiously-introduced home benefits, clients have often been unwilling to accept the amount recommended by the case manager. This reluctance has been attributed to a concern about becoming over dependent on a program as a possible first step toward a nursing home, and also to a dislike of being out of control of what occurs in one's own home. Judging from the Continuing Care Program Manual, Manitoba seems to have developed a flexible and practical approach to its allowable services.

Some insights for the Continuing Care Program are available from its internal data. Figure 1 traces the growth in the various Continuing Care services. Although there has been growth in all three areas, nursing services have shown a particular recent surge. The growth in home care assistance is traced in Figure 2.

The numbers of persons served has increased faster than the numbers of admissions, suggesting that clients are being retained longer. This conclusion is bolstered by an increase in the costs per person served. Some clues about targeting can be gleaned from Figure 3, which portrays the case coordinators' judgments about the likely alternative for home care clients. Over time there has been an increase in apparent hospital substitution, with less PCH effect. Overall, there is a decreasing proportion who would likely have remained in the community without care.

Experience of demonstration projects in the United States suggests some circumstances that drive costs upward. For example, if agencies from which services are purchased demand 4-hour or even lesser minimums for service, costs will increase. Jurisdictions that purchase service usually have moved to eliminate such preconditions; once a public entity becomes the major purchaser of care in an area, such negotiations are feasible. Arbitrary expectations for heavy professional supervision of paraprofessionals can also be costly. In some areas in the United States, competitive bidding has been required for the purchase of home care in an area, and public home-care programs have become embroiled in rules such as requirements that a single contract go to the lowest bidder. Generally, it has seemed advantageous for home care programs to retain greater flexibility and less dependence on a single service provider.

In the United States, potential liability serves as a check to the most cost-effective and practical plans. (Actual liability suits regarding home care have rarely occurred in the United States, but the fear of a suit casts a pall on care plans.) It would often be cheaper as well as more consistent with the client's wishes, for example, to pay neighbors to look in at intervals and help clients transfer in and out of bed (at hours more conducive to their preferences), to bring in meals, or to transport the client, but some programs shun non-agency vendors because of liabilities that would be incurred in case of injury to either the client or the care-giver. Assuming that Manitoba is a less litigious society, economies may be effected through unconventional plans, particularly in rural areas.

Another issue frequently raised is the proper relationship between case management and service delivery. Some argue that those who directly give care should not also be in the position of prescribing care plans. For example, a hospital that has its own home-care agency and, in addition, has motivations to discharge the patient, is not an ideal post-hospital care planner. Similarly, according to this line of argument, visiting nurse associations that deliver home nursing and home care should not also make program determinations that result in some clients entering their own caseloads and others being shuttled elsewhere, or even that result in their designating the levels and mix of service required. From the material available to us, we cannot tell if the role of the VON in Manitoba (in determining who should be considered short-term and who long-term in the absence of explicit criteria with predictive validity) and the role of regional care coordinators (who influence decisions about who should receive care from the Continuing Care program's resources and who should be processed for Personal Care Home admission) are problematic in this regard.

Available information about adult day care from jurisdictions in the United States is unencouraging. Adult day care, as a socialization program, is not highly valued by its consumers, and even subsidized slots tend to be under-utilized. It also tends to be an expensive program, partly because of transportation costs. Adult day care alone cannot enable the functionally impaired to stay in the community, and the marginal advantages of adding a few days of adult day-care to homecare have not been demonstrated. In the United States, the most vociferous proponents for adult day care are the providers rather than the users. It appears that adult day care in Manitoba is a service accessed through case coordinators but financed by the Health Services Commission, so that the costs may not be a visible part of the community care services. Experience in other jurisdictions would suggest, however, that it would be worthwhile to take a careful look at which populations are served by adult day care, at what cost, and with what effects.

QUESTION 2: TRENDS IN EXPENDITURES AND UTILIZATION

We have already commented on the need for a better linked system of information between Continuing Care and the Health Services Commission. Nonetheless some comparisons can be made by examining trends in utilization. It is important to recognize that these trend analyses raise more questions than they answer. The patterns are just that; they do not represent any insight into the factors causing them. Figure 4 traces changes in rates for hospitals, personal care homes and continuing care, adjusted to put them into a comparable scale to look for patterns of change. The crowded figure shows changes in rates for the overall groups and for the elderly. In general, there is a modest increase in the rate of hospital use, a slight decrease in PCH use and an increase in Continuing Care activity.

Figures 5-7 explore these changes in more detail. Figure 5 traces the increase in hospital days per population. Figure 6 shows a slight decrease in PCH use, based on either the whole population or those aged 65 and older. Figure 7 traces the increase in the Continuing Care caseload.

Figure 8 examines the overall costs of care. Hospital costs are rising fastest. Continuing Care has shown a recent spurt reflected in the services graph. PCH and medical services have been increasing less rapidly than the former two.

Evidence of Continuing Care's effect on displacing care in other LTC sectors can be sought in several ways. Figure 9 looks at the changes in the proportion of elderly persons in different forms of long-term care over a 10-year period. Home care has shown some growth, PCHs some slight reduction. The waiting lists for PCH in the hospital and the community have shrunk. Although the age-mix in home care has shown some increase in the elderly (Figure 10), there is no change in the PCH age-mix (Figure 11). Further evidence of PCH displacement by home care can be sought in changes in case mix in PCHs. Figures 12 and 13 show that the overall modest PCH caseload reduction occurs in the number of Level 1 cases for both the overall caseload (Figure 12) and the elderly (Figure 13).

QUESTION 3: PATTERNS FOR HOME CARE, PERSONAL CARE HOMES, AND HOSPITALS, AND LINKAGES AMONG THE SECTORS

Question 3 has a quantitative and qualitative component, the latter dealing with working relationships among the three sectors. We shall first discuss the utilization and cost patterns, and then the interactions among the sectors.

Utilization and Costs

Ideally, it would be helpful to generate a prescriptive statement about what proportion of the general population (or the population over age 65) should be served by a home-based program such as Continuing Care. No absolute formulas exist, however. The rule-of-thumb that about 5% of the population over 65 is in a nursing home at any given time and that 2 or 3 persons with the same functional impairments reside outside nursing homes leads to the suggestions that perhaps 10% to 15% of the population over 65 might be served by the Continuing Care Program. However, this is an imprecise and upper-bound figure.

The data shown in Figure 9 suggest that since 1976 the proportion of elderly treated in home care has risen from 5.2% to 7.7% in 1987, while the proportion in PCHs has fallen from 6.2% to 5.7%. Together the proportion waiting in hospitals or home care for PCH placement has fallen to less than 1%. Thus, the Continuing Care Program, at least in terms of numbers of clients, does not seem to be over used. Less can be said specifically about targeting those services to those in greatest need, but there is no reason to suspect a problem in this area.

In other provinces in Canada and in jurisdictions in the United States where home care is offered on a universal basis (e.g., the State of Massachusetts, which purchases homemaking for the functionally impaired regardless of income, or Oregon, where funding streams have been pooled to create almost universal coverage), it seems that after the initial program build-up, home-care utilization stabilizes at somewhere between 10% to 15% of the population over age 65. Moreover, many of these clients use very small amounts of homecare, and program officials often express that the advantages of linking them to the system justify the small costs in infrequent service. In home care, as in other services, it seems that a relatively small proportion of the clientele account for a relatively high proportion of the costs.

Manitoba's costs for the Continuing Care Program have steadily risen at a rate of about 19% a year after 1977, and this rate is too high to be accounted for by inflation or by the increase of caseloads. Without providing the value-judgment about whether the increase in costs have been too great, earlier we have attempted to compare patterns of utilization and cost in the Continuing Care Program with patterns in use of personal care home and hospitals.

As shown in Figure 7, the rise in the caseload of the Continuing Care Program is about the same for both these over and under age 65 whereas the caseload of those 65+ has increased in the past year (Figure 10). In recent years the fastest growth has occurred in the nursing services and home care, as distinguished from home support.

Linkages Among the Three Sectors

Hospitals, personal care homes, and home care services are naturally linked. Use of any one is likely to affect the use of any other. Much of the entry into one service comes after discharge from another. Changes in one sector affect the others. For example, as already mentioned, in the United States changes in the payment of hospitals has produced incentives for more rapid discharge. In turn, this means patients are admitted to home care and nursing homes more ill than formerly was the case. Indeed, a whole new care form, labelled transitional care, has sprung up as a result of the change in hospital reimbursement.

The points of interface become very important. Hospital discharge planners, under pressure to move hospital patients out, may not be in the best position to study alternatives placements, especially if there is a difference in their availability. Nursing homes may want to move patients into hospital as soon as their care needs increase, even when the problems might be managed in the nursing home with a little more attention. Home care can serve as an alternative to both nursing home care and acute care.

Increasingly, care previously thought to require a hospital environment is being rendered at home or in the doctor's office. Thus, separate sponsorship for each modality of care may complicate the substitution of one form for another. Similarly, affiliating home care with one sector over another will ignore at lease part of the natural linkage and concomitant substitution potential.

In the United States, there have been several demonstration efforts to link these three forms of care more closely. Because the U.S. situation is so dominated by the differences created by the unique mixture of welfare and insurance funding, great care must be taken in extrapolating this experience to the Manitoba situation, but some useful lessons can be learned nonetheless. Much of the merging has been done through some form of capitated payment whereby a single provider organization receives moneys from different agencies to provide all the care needed by a group of clients.

The Continuing Care Program is separated from the acute care sector in terms of both funding and management. This separation need not impose any special hardship on the program's clients as long as the principle of their eligibility for the full range of acute care services is met. Use of long-term care should not imply any lessening of eligibility for acute care. By design the Continuing Care Program has avoided one of the problems plaguing such efforts in the United States and elsewhere (including to some extent Ontario). The physician is not the central figure in initiating or establishing long-term care. The advantages to avoiding a system dominated by physicians is obvious. Most of the care required is not the sort physicians are especially competent to prescribe or direct. The necessity for their active involvement elsewhere has created situations where needed care may not be ordered or the process to obtain physician attention is time consuming and non-productive.

However, physician involvement in long-term care is often an essential ingredient. If physicians feel by-passed or diminished, their withdrawal of attention to the acute manifestation aspects of the client's problem can have dire consequences. In some instances, important, potentially treatable problems may not be recognized as such by the assessors, and links with primary care providers are too limited to allow communication. The panelling process is designed to catch some of these cases, but it is limited primarily to those clients about to enter a PCH.

We expect that the Continuing Care Program needs to strengthen its ties with the geriatric expertise available at least in the urban centers to develop mechanisms to encourage attention to correctable problems. For example, it may be possible to use some types of forms or checklists to assist the assessors in assuring that treatable issues were addressed. In general, the available experience in the United States, other parts of Canada, Britain, and Europe have shown that geriatric workups are capable of altering the trajectory of patients destined for institutional care. (See Kane, Kane & Rubenstein, in press for a review of this research). To achieve this effect, however, one must target the geriatric assessment to those with multiple, perplexing functional problems rather than to make it available to all persons over a certain age.

Despite the separation in organization, just as in the United States changes in the hospital sector will profoundly affect activities in the community. Manitoba hospitals have an added buffer in the form of extended care beds, but again an important aspect of a well-linked system would be targeting of those hospital beds to persons truly in need of that heavier level of care.

Some of the ideas currently discussed in the United States are designed specifically to link acute and long-term care better. In Massachusetts, for example, there is presently discussion about linking the efforts of the two major governmental units responsible for long-term care, the Office of Elder Affairs and the Department of Welfare. The former operates the home care program and the latter the nursing homes and some health-oriented home care. Under terms of the agreement, they would coordinate intake, assessment and case management, agreeing on a uniform system and uniform instruments. This would bring them up to the current level of integration of the Manitoba program. Among the motivations for such a merger is increased interest in encouraging the development of prepaid capitated systems of long-term care, preferably ones that link acute and long-term care services. This development reflects earlier discussion here about the potential for closer linkages between acute and long-term care and the desirability of establishing better controls on funding through budget ceilings that can be established and monitored. In a sense, Manitoba already has the structure for a capitated system, since there is geopolitical accountability, but the structure has not been used in that way to hold the managers to strict budget limits.

As already stated, demonstration projects have been established in the United States to link acute and long-term care on a capitated basis. One of the best know systems for delivering such care is the On Lok program in San Francisco's Chinatown. This relatively small program serves about 400 disabled elderly persons, providing a full range of services, including both acute and chronic care. It operates from a social service model, but contracts with (or hires) physicians to provide medical services in this socially dominated context. The evaluations of the program have compared its expenditures to those for a matched set of clients under ordinary care, and found substantial reduction in the use of hospitals and nursing homes among On Lok clients at lower overall costs of service favor. Because the program is small, it is difficult to estimate how easily such a model can be widely reproduced. At present, there are four other programs in different parts of the country getting underway using the On Lok approach.

Another model being tested in the U.S. is the Social Health Maintenance Organization (SHMO). This model is an extension of the health maintenance organization (HMO) with the addition of long-term care services at home and in institutions. In its simplest form, it represents a merger of prepaid acute care with at least limited LTC insurance. Its rationale stems fiom a conviction that a modicum of LTC support given at critical times can prevent larger expenditures in acute-care, and that some dollars from the acute side can be moved to the long-term care side with overall savings resulting.

Four demonstration S/HMOs are underway; they are located in Brooklyn, NY, Long Beach, CA, Portland, Oregon and Minneapolis, Minnesota. Each S/HMO is a consortium of health care organizations that is responsible for providing or purchasing all the acute physician, hospital, and rehabilitative services that would be offered to any elderly Medicare beneficiary in the United States and also long-term care up to a fixed dollar limit that varies form site to site; the federal government pays a capitated amount for each member in lieu of their Medicare coverage, and members pay an annual fee for the additional services. Co-payments are also applied to the long-term care services. The programs allow for use of core resources with dollar shifting from one category of care to another. The mandated enrollment formula requires that initially the disability levels in the membership mirror that in the elderly population. Case managers employed by the S/HMOs assess members to determine whether their disabilities qualify them for the additional care, and then allocate that care according to care plans.

The Social HMOs have been well described (Leutz, et al., 1985), but it is too soon to determine the results. For Manitoba, the most useful information to emerge is likely to be the specific technologies used by the case managers to estimate the costs of care plans. It also appears that some of the S/HMOs are using to their advantage brief stays in long-term care facilities prior to discharges to home care. In Manitoba, it appears that admissions to Personal Care Homes are more final than one finds in the United States, where considerable short-term use is made of the nursing home. Perhaps this occurs because the case coordination stops at the personal-care home door. On the other hand, this comment must be tempered somewhat: the data from the United States overstates the number of short admissions because each hospital stay followed by a return to the nursing home looks like a new admission in the statistics, whereas Manitoba appears not to have this problem in its data.

QUESTION 4: SPECIAL POPULATIONS

We have been asked to comment on the potential relationship between the Continuing Care Program and service to other populations such as younger disabled persons and mentally ill persons. First, apropos of chronically and seriously disabled adults, it seems clearly useful for them to receive home-based services under the same guidelines and case coordination as would an elderly adult. In this policy, Manitoba is consistent with all other Canadian provinces and with the most advanced states in the United States. To the extent that both groups are likely to need personal care and homemaking services, it is inefficient to separate the clientele by age. Indeed it may be that when case coordinators work with both the younger and older clientele, they gain an appropriate corrective against a tendency toward paternalism with regard to the old. For example, it has been noted that adult disabled persons in the Untied States have tended to lobby for the right to hire and supervise their own care attendants. Professionals are often more willing to grant that degree of autonomy to a younger disabled person, yet an older person who is cognitively intact may have a similar wish and need for control. Younger disabled persons may also need referrals to vocational rehabilitation, and, once reaching a stable situation, may experience some needs associated with retaining a position in the workforce (e.g., special transportation).

The issue of mental illness is more complicated. In many places in the United States, task forces are struggling to better integrate long-term care and other social services with mental health services. Typically, as in Manitoba, various states in the United States develop parallel case management for the mentally ill. It seems to us that this separation might be quit appropriate in terms of the chronically mentally-ill (CMI) as long as good communication exists between the two programs. Unless that CMI individual also has a physical problem, his/her need for home care and home nursing is quite minimal. More likely, in the case of some rather isolated chronic schizophrenics, there will be need for a protected housing situation. The need for home nursing would probably focus on monitoring of medications, which also can be done on an out-patient basis in connection with psychological and supportive treatments. It would seem that one of the main points of interaction with Continuing Care could be around the placement process -- it would be important for case coordinators to be well aware of residential resources for the CMI in their region, and to have clear criteria for when a Personal Care Home would be appropriate. Perhaps some of the homes that largely housed Level 1 clientele prior to home care's ready availability might be suitable.

At present, in the United States, there has been an energetic effort to improve the care of the CMI (Mechanic and Aiken, 1987). The Robert Wood Johnson Foundation recently funded nine city-wide efforts in large United States cities to rationalize and reorganize care for the CMI. The National Institute of Mental Health has also funded a series of similarly motivated projects. The Community Mental Health Center network is thereby challenged to interact with other local organizations to provide a better, more responsive service to the CMI -- including interaction with housing officials, police and courts, income maintenance, and vocational rehabilitation. It would seem that a group categorically dedicated to the mentally ill would be the most appropriate lead organization and the Continuing Care Program would play a supporting role in such an effort in Manitoba.

The situation differs when we consider the mental health needs of elderly persons already receiving the help of the Continuing Care Program. Typically older persons do not receive referrals for psychological treatment of depression and other treatable mental health problems, and it would be important for the case coordinators to be sensitive to those needs. For example, it has been pointed out by Steve Zarit and others that persons giving heavy care to relatives (particularly those living in the same household) have more than average need for service (Gilhooley, Zarit, and Birren, 1986).

Alzheimer's Disease and other dementias have received considerable attention in the United States in the last ten years, and the lack of clear responsibility for that population has been pointed out. Typically, a person with dementia would fall under the rubric of Continuing Care because of the multiple functional impairments and the need for compensating care. It is unclear from the statistics whether Manitoba's home-based services have been able to meet the needs of persons who are demented; in our experience this group has not been well-served at home. It may be that specialized lodging is needed, apart from the general population of personal care. As the agency responsible for placement, this issue should be of interest to the Continuing Care Program.

We note also that the needs of children with chronic (often congenital) disabilities bear many parallels to the needs of the elderly. We have no specific recommendations to make about this population, except that the care coordinators would need the necessary information to coordinate with particular agencies for the education, training, and recreation of children. Because disabled children in the community generally have parents who are responsible for household upkeep, the main services required from Continuing Care would likely be home nursing and other therapies and health instruction of parents.

QUESTION 5: CAPS

As the previous discussion indicates, per-person and per-program caps on expenditures are regular features of case-managed long-term care programs in the United States and in Canada. We would urge that sort of program accountability in Manitoba as well. It does seem that case coordinators are limited in their expenditures per-client to an amount no greater than the same client would cost in a care facility. However, we need clarification about what expenditures are counted toward that cap. In that regard, it would be necessary to decide how to attribute the care coordinator's time. Also a per-program cap would seem a useful step rather than an open-ended ability to generate expenditures.

In an ideal situation, there would be congruence between the responsibility for authorizing expenditures and the accountability for their amounts. It seems optimal if the case coordinators have responsibility for both institutional and non-institutional expenditures on behalf of a client whose care is being managed. That is the pattern in British Columbia, where case managers authorize level-of-care increases and decreases in facilities as well as in the community.

QUESTION 6: OTHER TRENDS AND ISSUES

An important area where more can be done in the Continuing Care Program is the formal mechanisms for assuring quality of care. Here again, the cultural differences between the U.S. and Canada are apparent. In the United States, the combination of public payment and private, for-profit provision of services leads inevitably to regulation, with its formal systems designed to anticipate endless litigation. Manitoba seems to share the Canadian preference for accommodation, where the regulator and provider see each less as adversaries and more as colleagues. (Indeed Manitoba has fewer proprietary providers than Ontario or British Columbia.) Nonetheless there is little in the way of formal quality evaluation, and some system would be useful.

For example, records are not used to assess the changes in clients. Evaluation of the success in matching resources to needs is left up to the care coordinators with no formal means to summarize their findings or to systematically identify consistently poor performers among the assessors or the care providers.

There are several areas of Continuing Care activity that deserve special attention buttressed by data. The program was put into place in a context that assumed, generally correctly, that good staff working in a supportive context with proper encouragement will do a good job. The reliance was placed on structure, supported by a developed manual of procedures. As events have transpired, there is a growing need for better data by which to monitor the activities and the results of those activities. The U.S. can shed very useful light on this issue, because the regulatory and administrative climate pushes constantly for more accountability. In an area like Continuing Care, which serves a wide variety of clients and overlaps with a number of other services, there is a stronger pressure to develop information that can indicate the outcomes of services and the characteristics of those served. Such information should include changes in status, expressed in terms of both location and level of function. The more such data are collected and recorded in a format independent of the location of service, the easier is comparison across modes of care.

Because the Health Services Commission has developed an extensive data system, it makes especially good sense to integrate the Continuing Care data into that system, at least to the point where clients can be tracked across different modes of care. This level has been achieved in some research studies in Manitoba, but only by painstaking hand linkage. A number of important questions are difficult to answer today for lack of better data. A great deal of interest has developed in the "careers" of clients in long-term care, tracing their movement in and out of different forms of care and correlating use in one sector with that in another. There should be a mechanism to relate service inputs to changes in client status. There should be a way to look for substitution effects more directly and to measure status changes at different points along a client's care continuum.

Related to the data issue is the need for a more effective system to monitor the quality of care along the range of activities administered by the Continuing Care Program. There is a growing appreciation in the U.S. of the need for developing better measures of quality in long-term care. The work of the many demonstration projects has led to some useful measures that reflect the transitions of patients and the types of activities conducted. The outcome measures have taken on a familiar list. The shift recently is to more consistent measures, using standardized formats to facilitate comparisons across programs.

The measures of quality in case management will use some of the same data elements to examine the decisions made by the case coordinator. Some of this already occurs at a more informal level in supervision and paneling, but a more systematic record, which presents the pattern of decisions by status and relates these to outcomes, can prove a very useful tool for monitoring the program as well as the performance of individual staff.

TABLE 1

Manitoba's LTC Provisions Compared to Ideal Criteria

Criterion	Manitoba's LTC Provisions
functioning central	uniform functional assessment process is used; services keyed to functional abilities
treatable problems assessments; detected and addressed	case managers can order medical panelling system is a structural failsafe; coordination between acute care and continuing care could be improved
range of services	includes geriatric assessment, homemaking, home handyman, home nursing, adult day care, health equipment, and personal care homes. Continuing program manages the initial entry to these program provides but has no operational responsibility or continuing eligibility function for personal care homes.
choice and consumer acceptability	decisions about level of care and site of care are separate; consumer choice is respected; program seems popular
acceptable quality and quality incentives	minimal system of quality assurance; no overt quality incentives, but good working relations exist between providers and payers, enhanced by manageable population size; some perverse incentives for case managers to refer difficult clients to personal care homes
visibility	easy access to clients and families; physician orders not required; regional and district offices established.
equitable re need	eligibility to programs and levels of care based on function

Criterion	Manitoba's LTC Provisions
family care supported/ equity across	program policy is to support but not replace family care; no penalties for family care and no legal requirements for; respite care for families is available
communication	interface between Continuing Care and personal care home program seems good; some discontinuities between hospital/ primary care and LTC; structural relationship between VON and regional case coordination difficult
public accountability	accountability inherent in public agency; but information about services, outcomes, and costs is not generated
cost-effectiveness	no evidence of waste, but no built-in incentives for cost-consciousness among case coordinators; some structural incentives to use purchase contracts in Continuing Care Program

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Relevant On-going Work

The National Governor's Association in Washington, D.C. is currently undertaking comparative studies of long-term care in several states in the United States. The Office of the Technology Assessment (which is a research arm of the U.S. Congress) is presently developing recommendations for optimal care of senile dementia. The American Association of Retired Persons has ongoing task forces working at the evolution of long-term care policy. Both the University of Minnesota and Mathematica Policy Research, Inc. are doing separate studies of post-hospital care.

Figure 1

Continuing Care Services

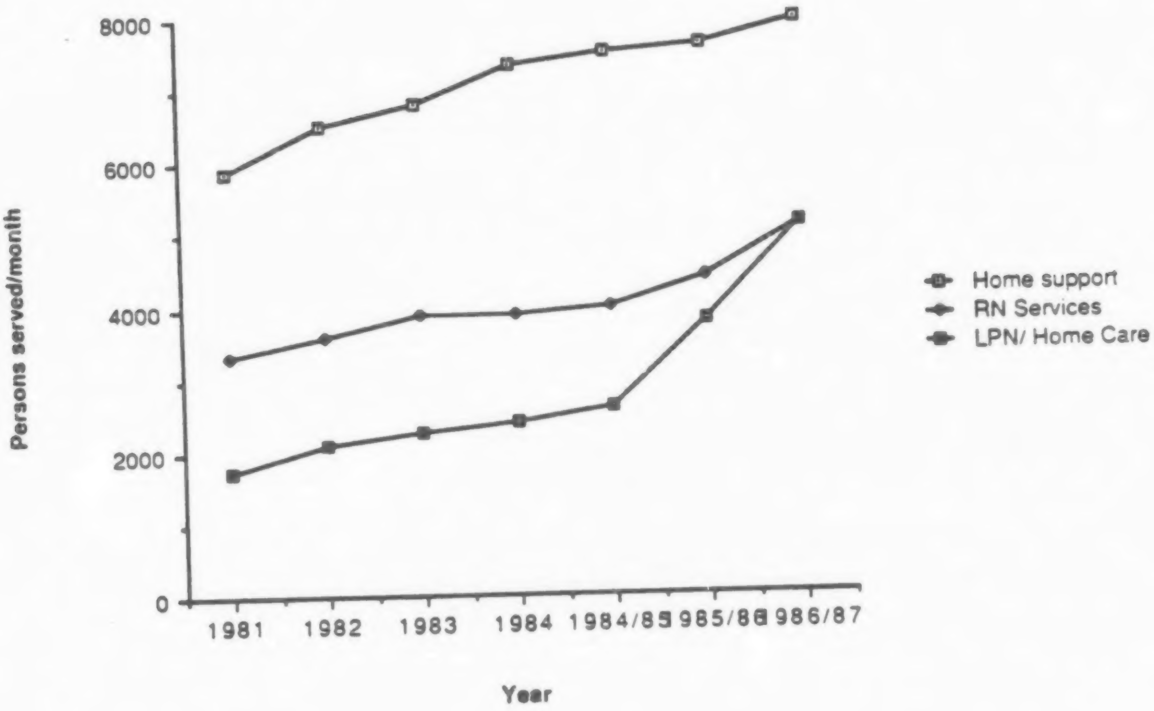


Figure 2
Home Care Assistance

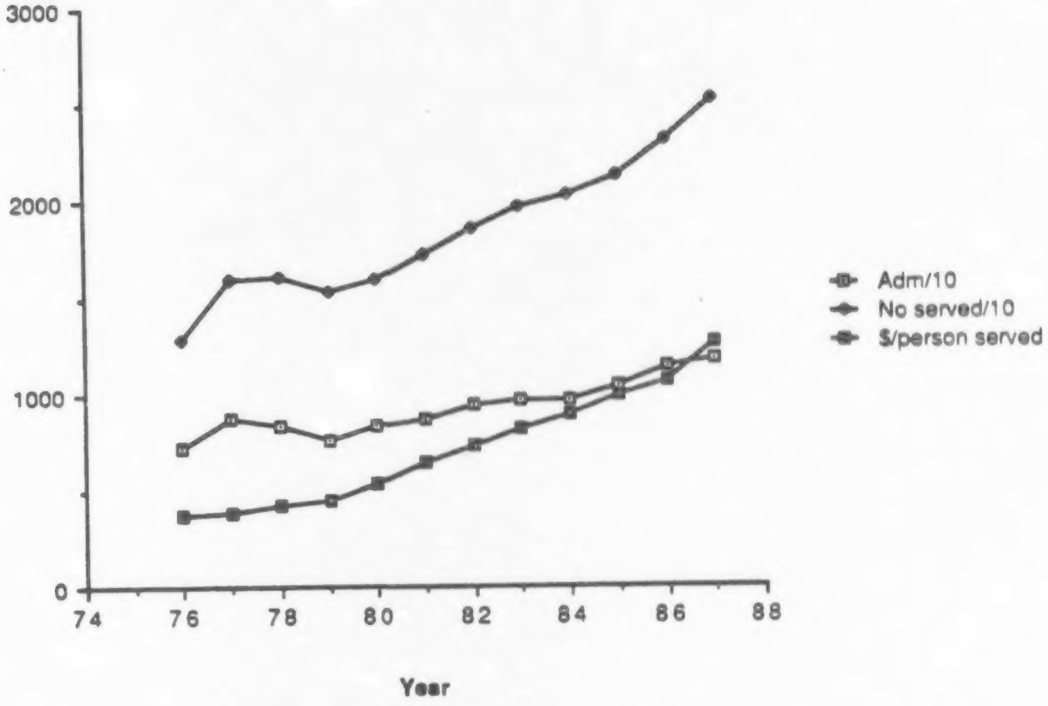


Figure 3

Alternative to Home Care on Admission

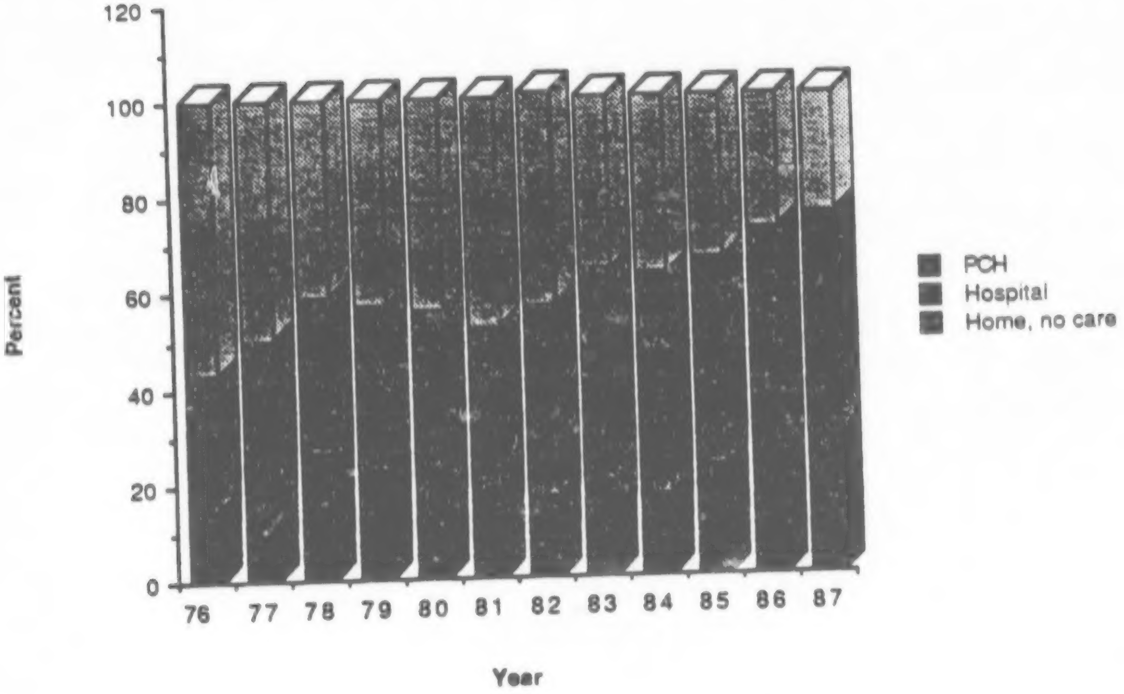


Figure 4

Changes in Hospital, PCH & Continuing Care

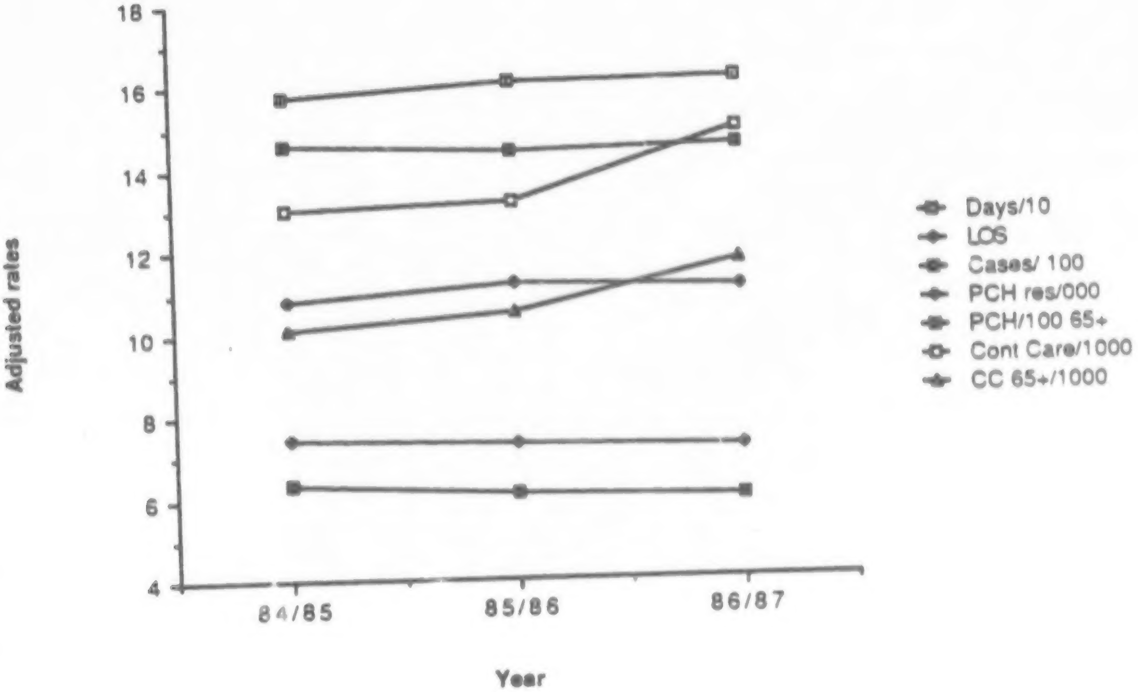


Figure 5

Hospital Use in Manitoba

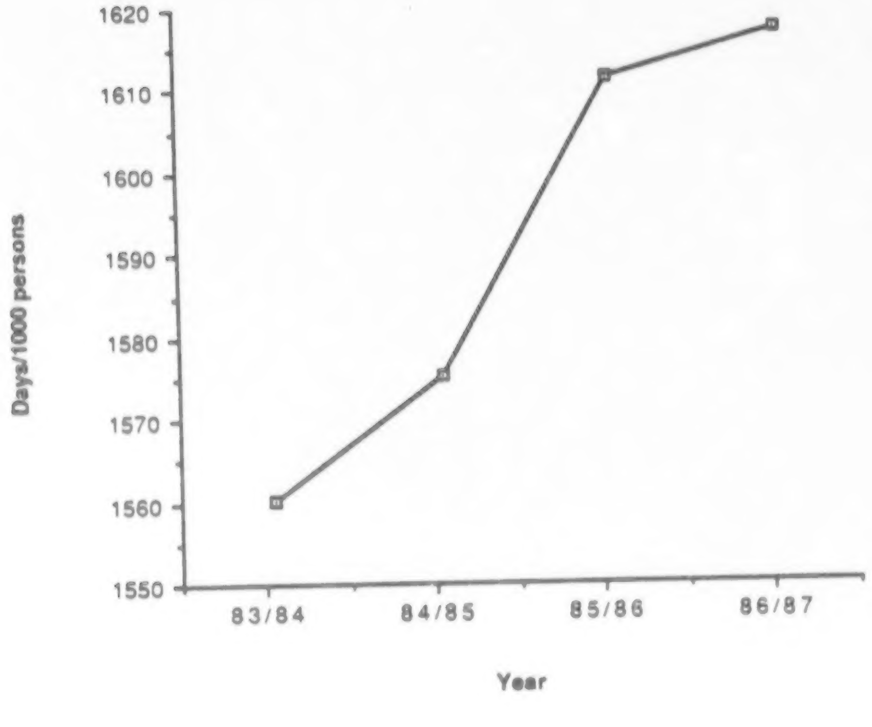


Figure 6

Changes in PCH Use

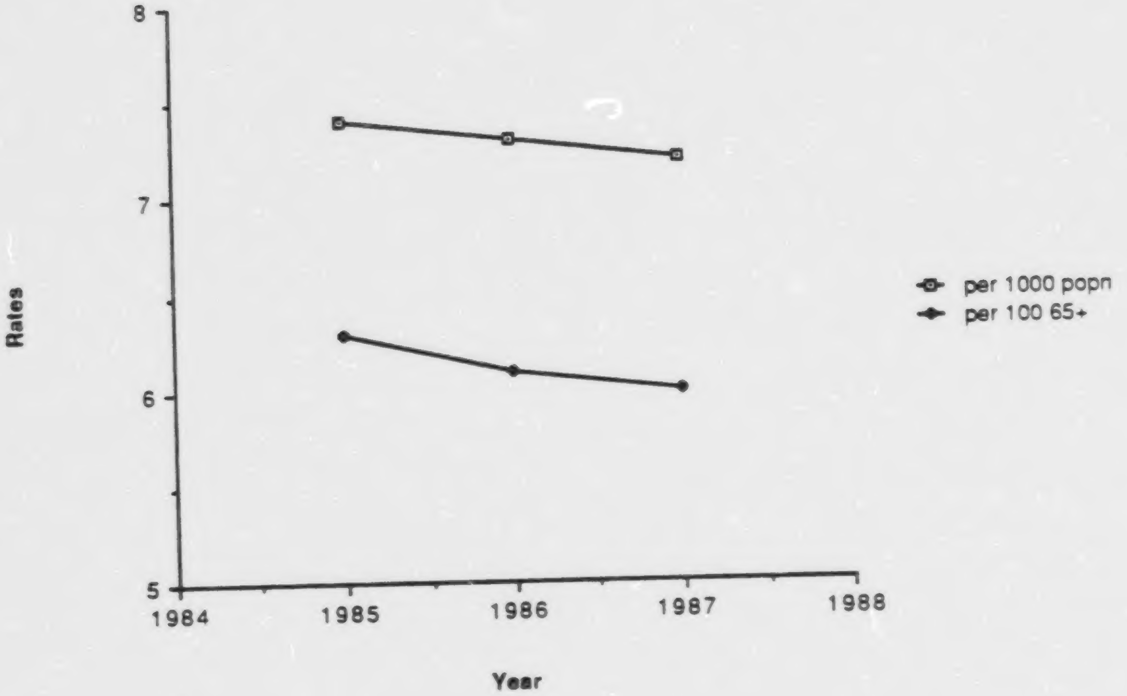


Figure 7

Continuing Care Caseload

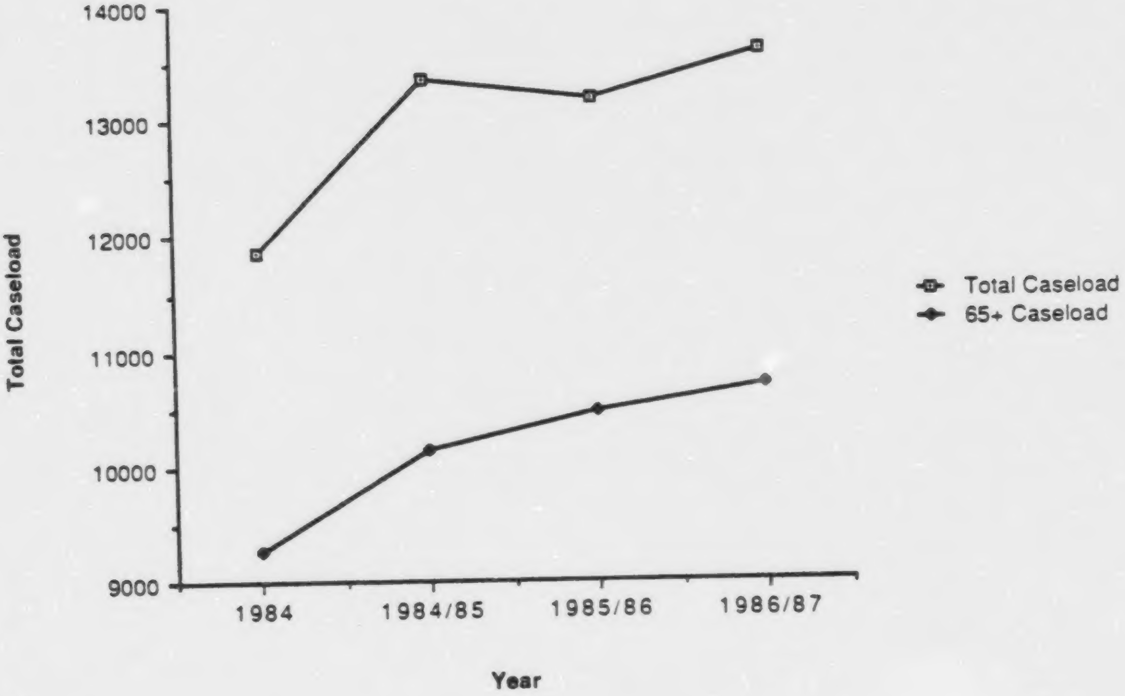


Figure 8
Manitoba Costs of Care

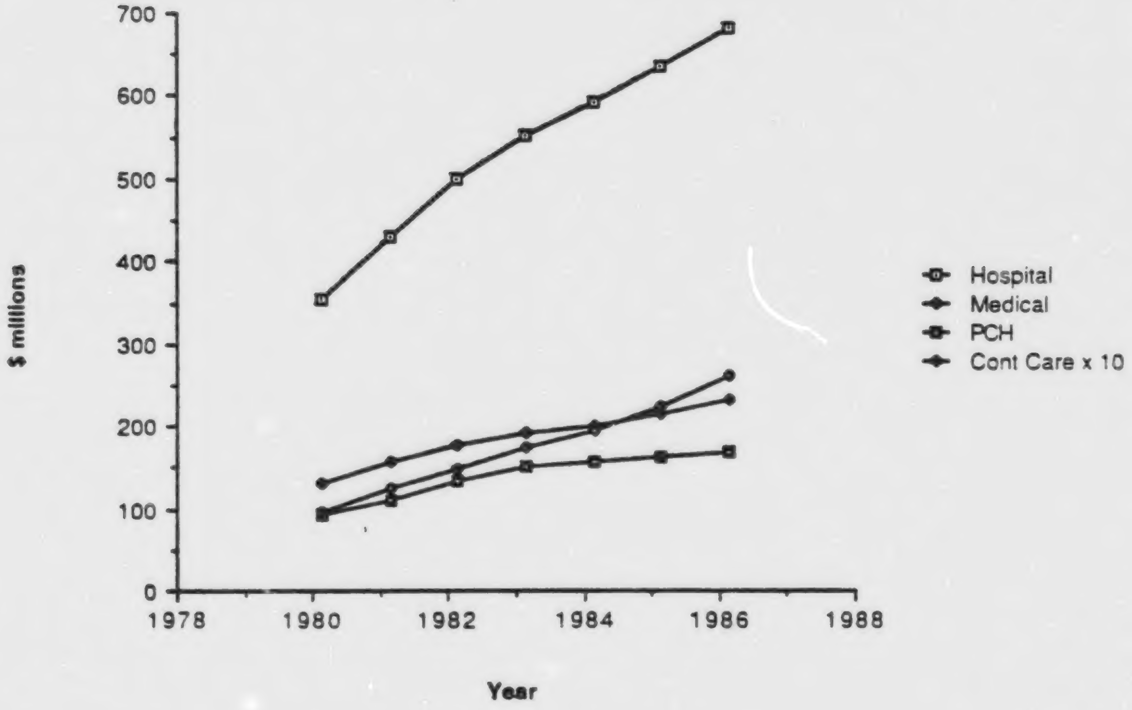


Figure 9

Changes in Proportion of Elderly in LTC

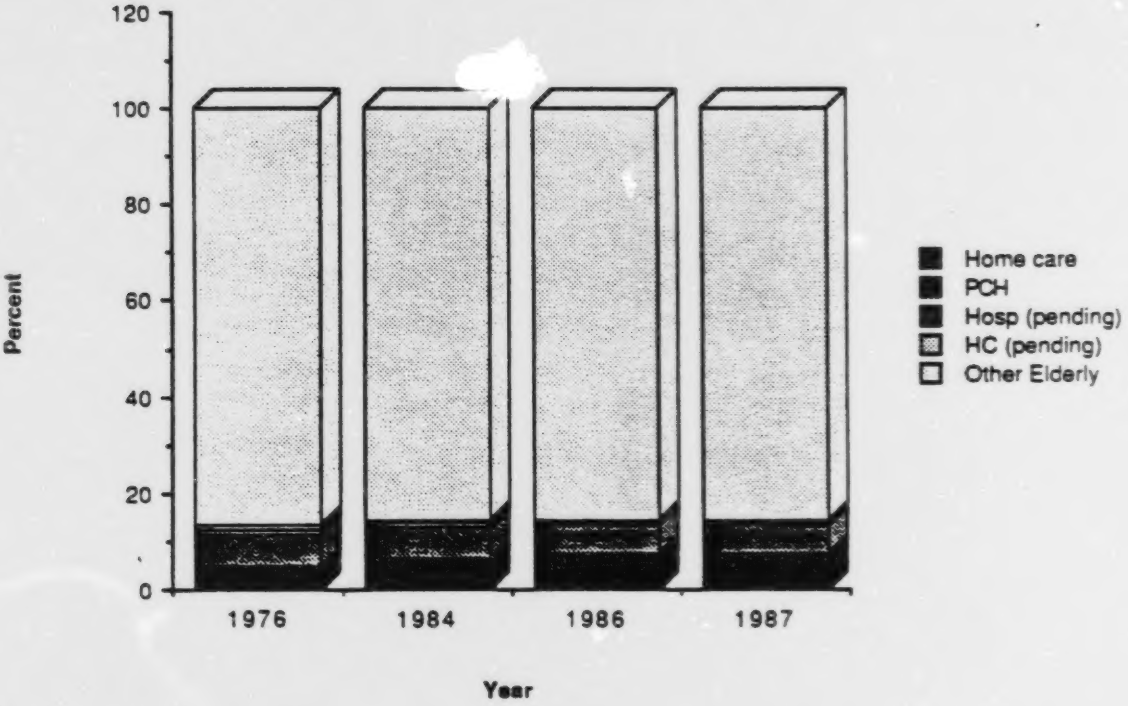


Figure 10

Manitoba Homecare Caseload by Age Group

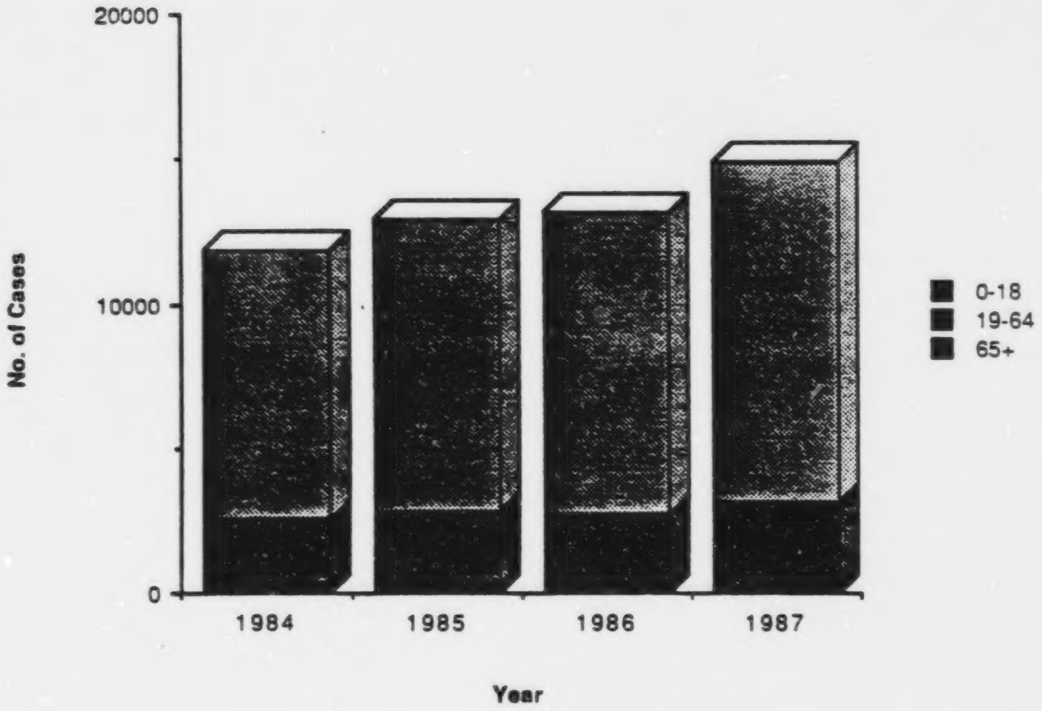


Figure 11

Age Mix in Manitoba PCHs

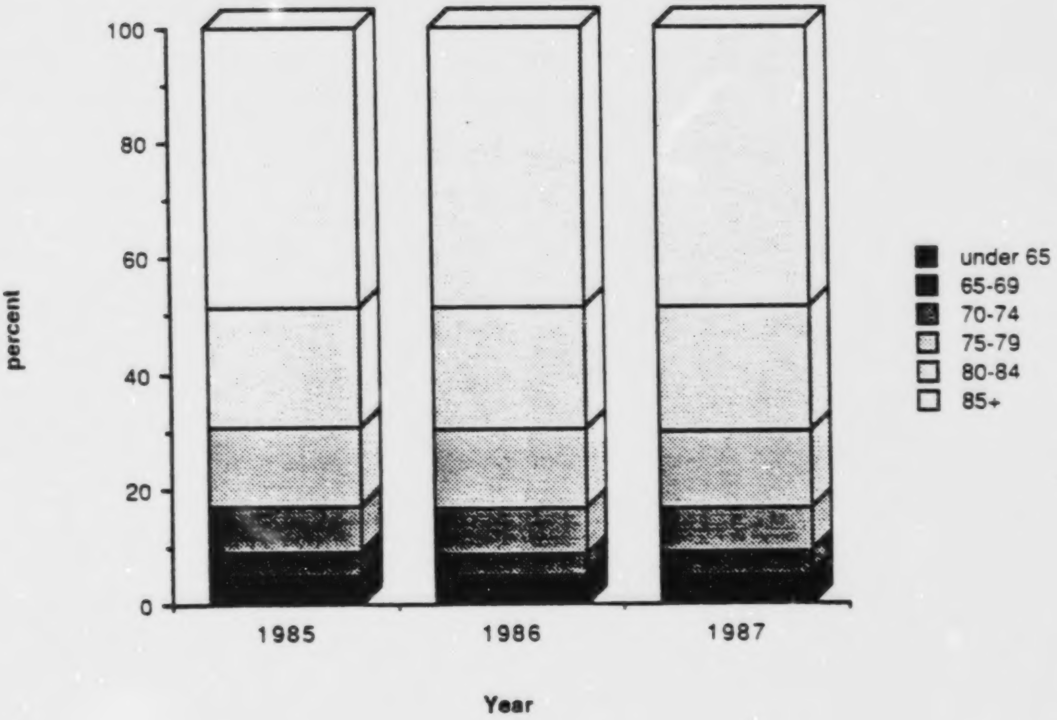


Figure 12
Manitoba PCH Casemix

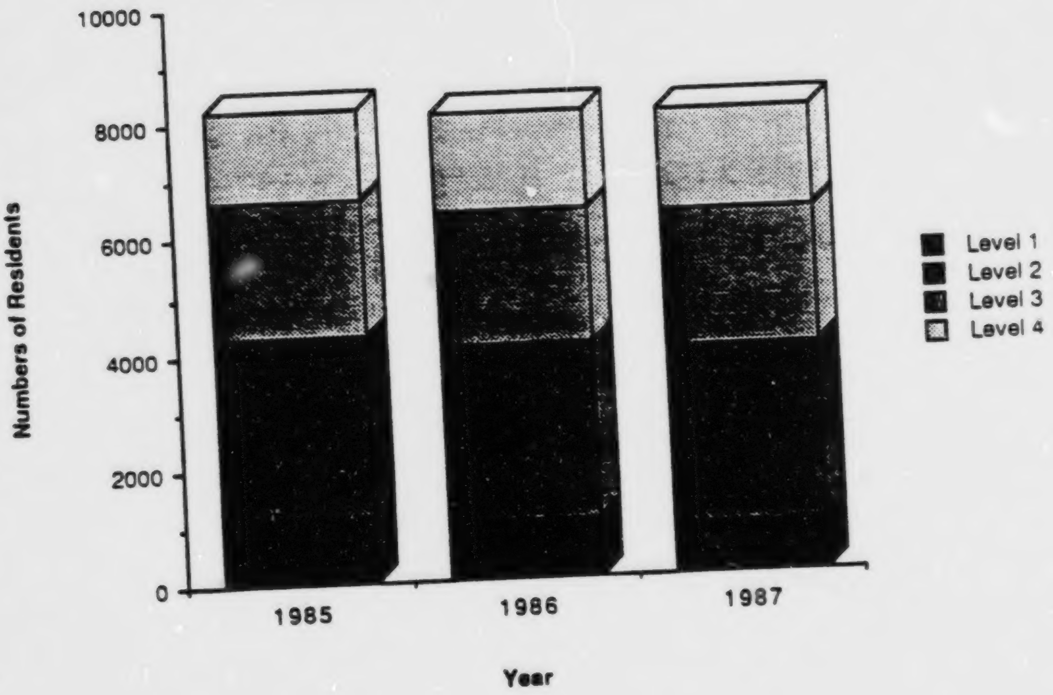
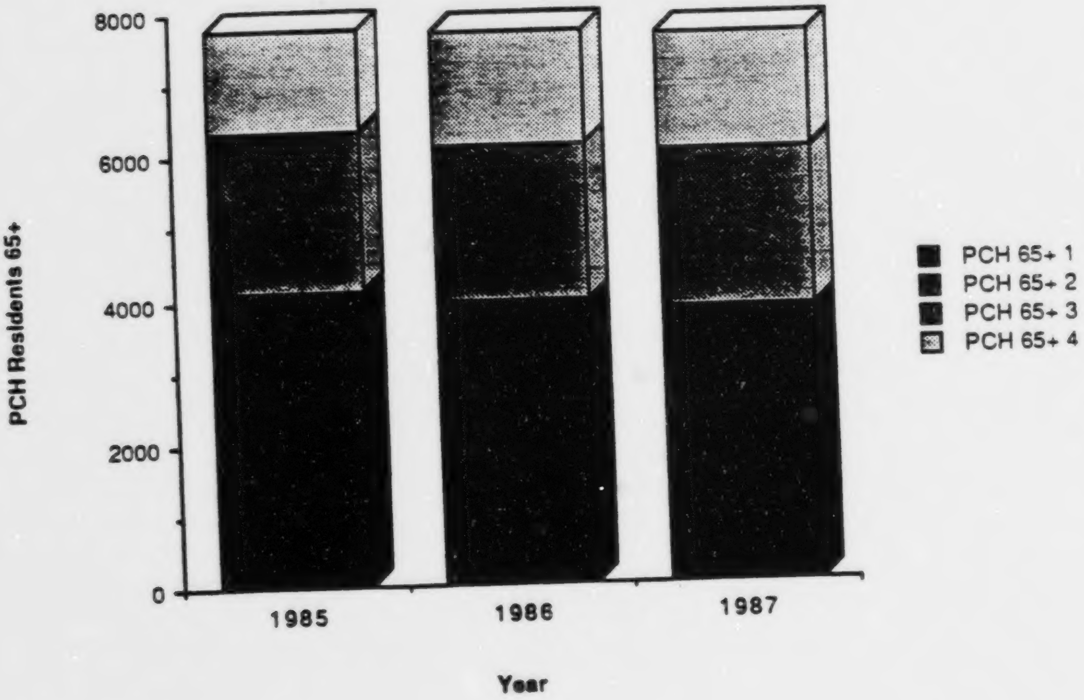


Figure 13

Changes in PCH Casemix 65+



Volume

3

Management
Consultants

Price Waterhouse

REVIEW OF THE MANITOBA CONTINUING CARE PROGRAM

VOLUME III

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APPENDIX A

TERMS OF REFERENCE

APPENDIX A

TERMS OF REFERENCE
EXTERNAL REVIEW OF THE CONTINUING CARE PROGRAM

1. Are the current outcomes of the continuing care program in line with the program objectives, especially in regard to health status in care, deinstitutionalization and client profile. Included will be a survey of clients to determine client satisfaction with the continuing care program.

2. Does the continuing care program require a legislative base? If so, what would be included in appropriate legislation? To what extent is the continuing care program already an institution requiring appropriate regulation? Is the present financial and budget structure sufficient to control costs? Or is that structure too inflexible to respond to program requirements?

3. Is there an effective long-term planning mechanism in place in the continuing care program? What are/would be the essential elements of such a mechanism? Recommend a planning process.

4. What are the demographic considerations that will drive future decision-making in the continuing care program? What impact will demographic changes have on health care needs and costs in continuing care? Will these changes be the major consideration in any future program expansion? Will the programs, of necessity, continue to focus on the elderly and disabled, or can it expand to include other elements in the population-at-large? What is the client profile now and what would the client profile be in an expanded program?

5. Why has there been a steady increase in both costs and number of

cases in the continuing care program? Are volume and price increase the main reasons for increased costs or are there significant management questions involved? What is the impact of advancements in technology on increased cost? What strategies would be required to limit costs and volume increases? If intake was limited, what would be the implications for health status and the placement of people in institutions?

6. What is the relationship of continuing care to deinstitutionalization in terms of number and costs? To what extent is continuing care aimed at people destined for personal care homes as distinct from those using only long-term community care? Is continuing care a suitable vehicle for an enhanced program of deinstitutionalization? What mechanisms and resources would be required to emphasize deinstitutionalization? To what extent can continuing care provide an outlet for long-term expenditure reduction in hospitals and other health care institutions and have an impact on future hospitalization patterns? What are the implications for continuing care on changes in hospital treatment patterns? Are there potential changes in physicians' patterns of practice that can assist the continuing care program? Should short-term extended treatment or respite beds come under the control of the continuing care program?

7. Evaluate the intensity of care and the deployment of professional staff to determine if levels are appropriate. Is there overservicing? Are there regional variations?

8. Evaluate staffing requirements and caseloads to determine what staffing ratios and caseload levels are appropriate.

9. Evaluate referral services and intake/assessment procedures to determine their appropriateness and uniformity.

10. Evaluate the case review procedure. Are referrals and discharges handled appropriately or are cases maintained too long?

11. Analyze and evaluate the labour and employment conditions in continuing care and the structure and composition of the continuing care labour force. Is the staffing structure appropriate? Are there significant problems in terms of working conditions? To what extent will possible changes in employment status, job descriptions, minimum wage, pay equity have an impact on costs in the continuing care program. Will the Victorian Order of Nurses continue to be an appropriate vehicle for service delivery?

12. Are there other programs delivered by government such as respite care, hospices or adult daycare that could be delivered under the continuing care program? Alternatively, are there services delivered by continuing care that would be more appropriate under another program? Are alternate forms of "home care" possible such as group living and other special care arrangements for the disabled?

13. Recommend appropriate financial record-keeping system.

14. Recommend an appropriate client/case management record-keeping system that also includes an evaluation mechanism.

APPENDIX B

LIST OF REVIEW INTERVIEWEES

APPENDIX B

INDIVIDUALS AND/OR GROUPS OF INDIVIDUALS INTERVIEWED DURING THE REVIEW OF THE CONTINUING CARE PROGRAM

OFFICE OF CONTINUING CARE

E. Thompson - Past Director
M. Barbour - Acting Director
C. Lussier - Acting program Administrator
J. Porth - Program Specialist - Nursing
E. Goerz - Program Specialist - Social Work
M. Lamonte - Program Information Coordinator

MANITOBA HEALTH SERVICES COMMISSION

F. Anderson - Administration - Director
P. MacDonald - Urban Health Consultant
K. Thompson - Director - Long Term Care Programs
L. Bakken - Special Program Consultant
G. Neill - M. I. S.
R. Chase - M. I. S.

PROVINCIAL HEALTH DEPARTMENT

J. Kaufman - Associate DM - Health
S. MacDonald - ADM - Community Health
F. Maynard - ADM - Administrative Services
L. Searcy - Director - Administration and Finance
D. Pascoe - Director - Research and Planning
K. Scherer - Assistant Director - Research and Planning
B. Szabo - Manager - Program Budget Review
H. Klein - Agency Relations Coordinator
C. Jacyk - Director - Medical Supplies and Home Care Equipment
J. Ross - Executive Director - Rural Regions
J. Robson - Executive Director - Winnipeg Regions
B. Havens - Provincial Gerontologist
T. Mattern - Special Projects

TREASURY BOARD

M. Mendelson - Deputy Minister
J. Clarkson - Analyst

COMMUNITY THERAPY SERVICES

E. Carabelle and Staff

CONSUMER ADVOCACY GROUPS

B. Haven - Manitoba Council on Aging
M. Chown - Manitoba Society of Seniors
F. Fleming - Creative Retirement
W. Lindsay - Creative Retirement
A. Simpson - Independent Living Resource

URBAN HOSPITALS REPRESENTED

St. Boniface
Health Science Centre
Grace
Municipal
Deer Lodge
Brandon
Seven Oaks

CONTRACTED AGENCIES

E. Carabelle - Administrator - Community Therapy Services (and staff)
M. Sussman - Administrator - 1010 Sinclair
P. Hawranik - Executive Director - Sr. Clermont

REGIONAL OFFICES

Regional Directors
Regional Continuing Care Coordinators
Program Supervisors
Case Coordinators
Resource Developers
Resource Coordinators
Administrative Officers

VICTORIAN ORDER OF NURSES - WINNIPEG

Executive Director
Short-term Care - Agency Director
Hospital Case Coordinators and Referral Nurses
Intake Nurse

APPENDIX C

CLIENT SURVEY QUESTIONNAIRE

APPENDIX C

CLIENT SURVEY QUESTIONNAIRE

Date and Time of Interview: ________________________________

Ask to speak to client. If client comes to phone, use explanation below. If client is identified as being unable to speak on phone/gone to an institution, etc., ask if person to whom you are speaking is a close relative of the client and give explanation below to them. (You may decide to try to contact client at new location.)

Hello, I'm ________________ of Price Waterhouse. We're conducting a survey on behalf of the Manitoba Department of Health on people who are currently receiving or have recently received services from the Home Care/Continuing Care Program (CCP) of Manitoba.

All of the information you provide to us will be kept confidential. It will not be shared with the staff or the Continuing Care Program nor will it in any way affect the services you receive from the Program. Our findings will only report general results, your name will not be identified.

I'd like to ask you several questions about the program.

If refused, reasons ____

____

Could I please have your (FILL IN RELATIONSHIP OF CLIENT IF SPEAKING WITH SIGNIFICANT OTHER) age? __ __ __

Client's Age:

0 - 18	1
19 - 64	2
65 - 84	3
85+	4
Refused	5

Client's Sex: (ASK IF NECESSARY)

Male	1
Female	2

Region: (RECORD FROM DATA CARD BELOW)

Rural

Westman (W)	01
Eastman (E)	02
Central (C)	03
Interlake (IL)	04
Parklands (PL)	05
Norman (N)	06
Thompson (T)	07

Urban

Winnipeg North (WN)	08
Winnipeg South (WS)	09
Winnipeg W. Central (WC)	10
V.O.N. (VON)	11
Children's Hospital (CH)	12
St. Boniface Hospital (SB)	13
Health Science Centre (HSC)	14
Municipal Hospitals (MH)	15

EXTERNAL REVIEW - CONTINUING CARE PROGRAM
CLIENT SURVEY QUESTIONNAIRE

Client's ID number: ______________________

Client's Name: ___________________________

Person interviewd:

Client 1
Relative .... 2 **Relationship** _________________________
Caregiver 3

(IF CLIENT NOT INTERVIEWED, STATE REASON)

____

____

I will start by asking you a few general questions. (For "significant other" -) I would like you to answer most of the questions from (Client's) point of view.

1. Which of the following languages do you (does he/she) speak most often? (CIRCLE ONE.)

English 01
French 02
German 03
Ukranian 04
Polish 05
Ojibway 06
Cree 07
Chinese 08
Greek 10
Other _______ 11
Not stated .. 12

2. What type of dwelling do you (does he/she) presently live in? (CIRLE ONE.)

House 1
Apartment 2
Elderly Persons
Housing (EPH) 3
Personal Care Home 4
Mobile Home 5
Other ___________________ 6
Not stated 7

3. What is your (his/her) marital status. (CIRCLE ONE)

Single 1
Married 2
Divorced/separated 3
Widowed 4
Other 5
Not stated 6

4. Where are your (his/her) closest adult relatives (excluding spouse) located? (CIRCLE ONE.)

In household 01
In building 02
Within three blocks 03
In the same city 04
Not is the same city,
but in Manitoba 05
Outside the province 06
In another country 07
Have no relatives 08
Other____________________ 09
Don't know 10
Not stated 11

5. At present, who do you (does he/she) live with? (CIRCLE ONE.)

Alone .... 1 (SKIP TO Q.8A)
With your spouse 2
With your relatives
(family .... 3 (CONTINUE)
With a friend 4
Other 5
Not stated .... 6 (SKIP TO Q.8A)

6. Are the individuals living with you (him/her) healthy?

Yes 1
No 2
Not stated ... 3

7a. Do the individuals living with you (him/her) work outside the home?

Yes .... 1 (ASK 7B)
No .... 2 (SKIP TO Q.8)

7b. (IF YES) What shifts do they work? (READ LIST. CIRCLE AS APPLICABLE.)

Days 1
Evenings 2
Nights 3
Weekends 4
Split shifts 5
Other ____________ 6
Not stated 7

8a. The next set of questions that I am going to ask you has to do with your (his/her) involvement with the home care/continuing care program. Were you or your family involved in the decisions regarding the type of services you (he/she) would receive to meet your (his/her) care needs? (CIRCLE ONE.)

Yes .... 1 (SKIP TO Q.9)
No .... 2 (ASK Q.8B)
Don't remember ... 3 (SKIP TO Q.9)

8b. Why not? ____

9a. Do you feel that the services you (he/she was) were offered adequately met your care needs? (CIRCLE ONE.)

Yes 1
No .... 2 Why ______________________
Don't remember ... 3

9b. Are you (Is he/she) still receiving services?

Yes .... 1 (ASK Q.9C)
No .... 2 (SKIP TO Q.10)
Don't know 3

9c. (IF STILL RECEIVING SERVICES) Do the services still meet your (his/her) care needs? (CIRCLE ONE.)

Yes 1
No .... 2 Why ______________________
Don't know 3

10a. Were the type of services that were put into place by the program staff what you (he/she) thought you (he/she) needed?

Yes .... 1 (SKIP TO Q.11)
No 2
Don't know 3

10b. (IF NO TO Q.10A), Were they more or less than what you (he/she) thought you (he/she) needed?

More 1
Less 2
Don't remember ... 3

11. Were your (him/her) preferences considered when the services were being ordered?

Yes 1
No .... 2 Why ______________________
Don't remember ... 3

12. In general, how would you rate your experience in initially obtaining services from the Home Care/Continuing Care Program? Were they very positive, positive, negative or very negative?

Very positive 1
Positive 2
Neutral 3
Negative 4
Very negative 5
Not stated 6

13a. Do you know how to register a complaint or how to appeal the service decision of the Program Staff?

Yes .... 1 (ASK Q.13B)
No .... 2 (SKIP TO Q.14)

13b. How do you register a complaint? (IF A SPECIFIC PERSON'S NAME IS GIVEN, PROBE:) Who is __________?

Contact family member 1
Contact friend 2
Contact social worker/coordinator..3
Contact nurse coordinator 4
Contact other program staff 5
Contact physician/doctor 6
Contact service worker 7
Other ____________________________ 8
Don't know 9

13c. How were you informed?

Program staff 1
Program brochures 2
Friend/Family 3
Service worker 4
Social worker 5
Other ________________ 6
Not stated 7

14. Our program records show that you (he/she is) are receiving the following services. (READ SERVICES CHECKED FROM INFORMATION ON FRONT PAGE. IF ADDITIONAL SERVICES ARE MENTIONED, RECORD THEM TOO. IF NOT RECEIVING SOME OF THE SERVICES, DELETE THEM. SHOULD THIS HAPPEN, CIRCLE "NO" IN Q.15C. OTHERWISE CIRCLE "YES".)

___	Homemaking (HH, HSW)	01
	Personal Care	
___	Attendant (PCA,HCA)	02
___	Orderly (Ord)	03
	Nursing Care	
___	RN (VON)	04
___	LPN	05
___	Physiotherapy	06
___	Occupational therapy	07
___	Adult day care	08
___	Respite Care	09
___	Equipment	10
___	Supplies/Dressings (Drsgs).	11
___	Meals on Wheels (MOW)	12
___	Community Therapists	13
___	Other ____________________	14
	Not stated	15

15a. Do you (Does he/she) receive all these services? (CIRCLE ONE.)

Yes .... 1 (SKIP TO Q.16)
No .... 2 (ASK Q.15B)

15b. (IF NO) Did you (he/she) at one time receive the other services?

Yes 1
No 2

15c. (TO BE ANSWERED BY INTERVIEWER ONLY) - Does the information in Q.14 tally with the information on the front page callsheet?

Yes 1
No 2

16a. Which service do you (does he/she) value the most? (READ ALL SERVICES IN Q.14 CIRCLE ONLY ONE RESPONSE. DO NOT ASK IF RESPONDENT RECEIVES ONLY ONE SERVICE. CIRCLE THE SERVICE UNDER 16A.)

		16a.	16b.	16c.
___	Homemaking (HH, HSW)	01	01	01
	Personal Care			
___	Attendant (PCA,HCA)	02	02	02
___	Orderly (Ord)	03	03	03
	Nursing Care			
___	RN (VON)	04	04	04
___	LPN	05	05	05
___	Physiotherapy	06	06	06
___	Occupational therapy	07	07	07
___	Adult day care	08	08	08
___	Respite Care	09	09	09
___	Equipment	10	10	10
___	Supplies/Dressings (Drsgs).	11	11	11
___	Meals on Wheels (MOW)	12	12	12
___	Community Therapists	13	13	13
___	ALL EQUAL	14	14	14
___	Other ____________________	15	15	15
	Not stated	16	16	16

16b. Which do you (does he/she) value the second most? (CIRCLE ONLY ONE RESPONSE. ASK ONLY IF RESPONDENT RECEIVED MORE THAN ONE SERVICE IN Q.14.)

16c. Which do you (does he/she) value the third most? (CI ONLY ONE RESPONSE. ASK ONLY IF RESPONDENT RECEIVES MORE THE SERVICES IN Q.14.)

17a. Do you (does he/she) think you (he/she) receive these services often enough? (READ SERVICES CHECKED IN Q.14 AND ELABORATE IN NEXT SECTION IF RESPONSE IS NO.)

		Yes	No	N/S
__	Homemaking (HH, HSW)	1	2	3
	Personal Care			
__	Attendant (PCA,HCA)	1	2	3
__	Orderly (Ord)	1	2	3
	Nursing Care			
__	RN (VON)	1	2	3
__	LPN	1	2	3
__	Physiotherapy	1	2	3
__	Occupational therapy	1	2	3
__	Adult day care	1	2	3
__	Respite Care	1	2	3
__	Equipment	1	2	3
__	Supplies/Dressings (Drsgs)	1	2	3
__	Meals on Wheels (MOW)	1	2	3
__	Community Therapists	1	2	3
__	Other ____________________	1	2	3

17b. Why do you say you (he/she does) do not receive ____________ services often enough.

____ __

Why do you say you (he/she does) do not receive ____________ services often enough.

____ __

Why do you say you (he/she does) do not receive ____________ services often enough.

____ __

Why do you say you (he/she does) do not receive ____________ services often enough.

____ __

18. Do you think you (he/she) need additional services? Do you (Does he/she) need ... (READ SERVICES NOT CHECKED IN Q.14 AND CHECK APPROPRIATE RESPONSE.)

		Yes	No	N/S
__	Homemaking (HH, HSW)	1	2	3
	Personal Care			
__	Attendant (PCA,HCA)	1	2	3
__	Orderly (Ord)	1	2	3
	Nursing Care			
__	RN (VON)	1	2	3
__	LPN	1	2	3
__	Physiotherapy	1	2	3
__	Occupational therapy	1	2	3
__	Adult day care	1	2	3
__	Respite Care	1	2	3
__	Equipment	1	2	3
__	Supplies/Dressings (Drsgs)	1	2	3
__	Meals on Wheels (MOW)	1	2	3
__	Community Therapists	1	2	3
__	Other ____________________	1	2	3

19. Let's go through the services you (he/she) receive. Do you (Does he/she) still need ... (READ SERVICES CHECKED IN Q.14 AND CHECK APPROPRIATE RESPONSE.)

		Yes	No	N/S
___	Homemaking (HH, HSW)	1	2	3
	Personal Care			
___	Attendant (PCA,HCA)	1	2	3
___	Orderly (Ord)	1	2	3
	Nursing Care			
___	RN (VON)	1	2	3
___	LPN	1	2	3
___	Physiotherapy	1	2	3
___	Occupational therapy	1	2	3
___	Adult day care	1	2	3
___	Respite Care	1	2	3
___	Equipment	1	2	3
___	Supplies/Dressings (Drsgs)	1	2	3
___	Meals on Wheels (MOW)	1	2	3
___	Community Therapists	1	2	3
___	Other ____________________	1	2	3

20a. Think of the services you (he/she does) do receive ... Tell me which areas could be improved upon (READ SERVICES CHECKED IN Q.14. IF NONE NEED IMPROVEMENT, SKIP TO Q.21, OTHERWISE ASK 20B FOR EACH SERVICE MENTIONED). Could _______ be improved? (ASK FOR EACH SERVICE.)

		Yes	No	N/S
___	Homemaking (HH, HSW)	1	2	3
	Personal Care			
___	Attendant (PCA,HCA)	1	2	3
___	Orderly (Ord)	1	2	3
	Nursing Care			
___	RN (VON)	1	2	3
___	LPN	1	2	3
___	Physiotherapy	1	2	3
___	Occupational therapy	1	2	3
___	Adult day care	1	2	3
___	Respite Care	1	2	3
___	Equipment	1	2	3
___	Supplies/Dressings (Drsgs)	1	2	3
___	Meals on Wheels (MOW)	1	2	3
___	Community Therapists	1	2	3
___	Other ____________________	1	2	3

20b. How could the ______________ services be improved?

____ __

20b. How could the ______________ services be improved?

____ __

20b. How could the ______________ services be improved?

____ __

20b. How could the ______________ services be improved?

____ __

21. Generally, how would you rate the services you (he/she is) are receiving? (CHECK ONE).

Excellent	1
Good	2
Fair	3
Poor	4
Don't know	5

22. Who would you call if you had a problem with your (his/her) services? (IF A SPECIFIC NAME IS GIVEN, ASK:) Who is ____________________?

Family member	1
Friend	2
Social worker/coordinator	3
Nurse Coordinator	4
Other program staff ______________	5
Physician	6
Service worker ______________	7
Other ______________	8
Don't know	9

23a. Do you have any concerns regarding the Home Care services that you (he/she) received?

Yes	1	(ASK Q.23B)
No	2	(SKIP TO Q.24)

23b. Please elaborate on your concerns. ______________________

____

24. Now, I'd like you to think back to the time when you (he/she) first contacted the Continuing Care Program. Think of what you (he/she) would have done if the CCP was not available. Would you (he/she) have been able to remain at home or would you (he/she) have moved elsewhere?

Remained home	1	(CONTINUE)
Move elsewhere	2	(SKIP TO Q.26)
Don't know	3	(SKIP TO Q.27)

25. If you (he/she) remained at home and home care had not provided services, which of the following types of help would you (he/she) have used? (CIRCLE ONE.)

Would not have used any help	1
Would have used help from family/relatives	2
Would have hired your own help	3
Other ______________	4
Not stated	5

(SKIP TO Q.27)

26. Where would you (he/she) have moved? (CIRCLE ONE.)

In with family and friends	1
Into a personal care home	2
Into elderly person's housing unit (EPH)	3
Other ______________	4
Not stated	5

27. Today, what would you (he/she) do if service limits were established for Home Care/Continuing Care? (CHECK ALL APPLICABLE ANSWERS.)

Manage with less service	1	(THANK & TERMINATE)
Pay to have someone deliver the service	2	
Ask family/friends to help	3	
Move	4	(ASK Q.28)
Don't know	5	(T&T)

28. Where would you (he/she) move? (CIRCLE ONLY ONE.)

In with family/friends	1
Into an elderly person's housing unit	2
Into a personal care home	3
Other ______________	4
Not stated/Don't know	5

Thank you for taking the time to answer all these questions about the Continuing Care Program. We really appreciate your participation. Thank you again. Goodbye.

APPENDIX D

DIRECT SERVICE WORKER QUESTIONNAIRE

APPENDIX D

CONTINUING CARE/HOME CARE PROGRAM
PROVIDING QUESTIONNAIRE

Please return this questionnaire to Price Waterhouse within 5 working days, in the enclosed, stamped envelope. All replies will be held in strictest confidence.

1. Where are you employed to do work for the Continuing Care/Home Care Program? (check one only)

   ☐ City ☐ Town ☐ Area

2. What type of work are you employed to do by the Continuing Care/Home Care Program? (Check one only)

   ☐ Home Support ☐ Daily Homemaker (24 hours)

   ☐ Home Care Attendant (Orderly) ☐ Licensed Practical Nurse

   ☐ Overnight Worker ☐ Registered Nurse

   (Licensed Practical Nurse, Registered Nurse) Skip to Question 4

3. Does your work require specialized training? ☐ Yes ☐ No

   If yes, where did you receive this training? (Check one only)
   Through the Program:

   ☐ At Red River C.C., H.C.A. course

   ☐ At Red River C.C., H.S.W. course

   OR

   Before you started working for the program:

   ☐ At Red River C.C., H.C.A. course

   ☐ At Red River C.C., H.S.W. course

   ☐ In another province

...2

4. Do you feel your training is adequate to carry out your work? Yes ☐ No. ☐
If no, please tell us what training you require. ____________________

____

____

5. Are you able to maintain your skills? ☐ Yes ☐ No. If no, please explain how this affects your work. ____________________

____

____

6. How do you get your work instructions? ____________________

____

____

7. Are your work instructions clear? ☐ Yes ☐ No. If no, explain how the instructions could be made clearer. ____________________

____

____

8. If you have questions about your work instructions, whom do you contact? (Check one only).

☐ Scheduling clerk ☐ Resource Co-ordinator

☐ Case Co-ordinator ☐ Other, please specify

____

9. What is the procedure you are to follow if your client's condition or needs change? ____________________

____

____

...3

10. What do you not like about your work with the Continuing Care/Home Care Program?

____

____

____

11. What would make your work with the Continuing Care/Home Care Program better?

____

____

____

12. Do you have anything else you would like to tell us about the Continuing Care/Home Care Program?

Thank you for taking the time to complete this questionnaire.

APPENDIX E

PROFESSIONAL ASSOCIATION LETTER

APPENDIX E

LETTER TO PROFESSIONAL ASSOCIATION

On behalf of the Manitoba Department of Health, Price Waterhouse is conducting an external review of the Continuing Care Program of Manitoba. As you are aware, the program provides:

1) client services to support the provision of care at home (Home Care) including family relief, respite care and adult day care;

and

2) client assessment for and placement into a long-term care facility.

The external review will focus on four areas: program scope and mandate, organization, operations, and effectiveness.

As part of this review, we are soliciting the opinions of relevant professional organizations. Specifically, we ask that you identify an individual spokesperson to represent your Association, who is qualified to communicate your organization's viewpoint, relative to the Continuing Care Program and particularly, the four areas identified:

1) Program scope and mandate;
2) Organization;
3) Operations; and
4) Effectiveness.

Please have your spokesperson submit his/her written comments by January 8th, 1988.

PROFESSIONAL ASSOCIATIONS RECEIVING LETTER
ASKING FOR INPUT REGARDING THE REVIEW OF THE CONTINUING CARE PROGRAM

Manitoba Pharmaceutical Association
Registered Psychiatric Nurses Association of Manitoba
Manitoba Speech and Hearing Association
Association of Occupational Therapists of Manitoba
Association of Physiotherapists of Manitoba
Manitoba Dental Association
Manitoba Optometric Association
Manitoba Chiropractors' Association
Manitoba Association of Gerontology
Manitoba Society of Medical Laboratory Technologists
Canadian Society of Respiratory Therapists
College of Family Physicians of Canada - Manitoba Branch
Manitoba Association of Medical Radiation Technologists
Manitoba Association of Registered Nurses
Manitoba Association of Licensed Practical Nurses
Manitoba Association of Registered Dieticians
College of Physicians and Surgeons of Manitoba
Canadian Medical Association - Manitoba Division
Psychological Association of Manitoba
Manitoba Association of Social Workers

APPENDIX F

FOCUS GROUP AGENDA

APPENDIX F

CONTINUING CARE PROGRAM

DIRECT SERVICE WORKER

I. INTRODUCTION

- purpose of study
- process for focus group
- confirmation of discussion questions

II. DISCUSSION

- is the orientation and training you have adequate for the job that you are asked to do?
- is the way in which work is assigned practical and fair?
- are the work instructions you receive adequate?
- do you have enough opportunities to talk to the staff you report to about any changes in the clients needs?
- how appropriate are the services that clients receive from home care?
- can you think of any ways to improve how home care services delivers are given to clients?
- do you find your work satisfying? What could be done to make it more satisfying?

III. SUMMATION

- summarize conclusions

APPENDIX G

PHASE ONE - REGIONAL/VON VISIT INTERVIEW GUIDE

APPENDIX G
INTERVIEW GUIDE INTENSIVE REGIONAL VISITS

EXTERNAL REVIEW - CONTINUING CARE PROGRAM
REGIONAL/VON VISIT INTERVIEW GUIDE

INTERVIEW LEGEND

Regional	
RD	Regional Director
RCCC	Regional Continuing Care Coordinator
SUP	Area Supervisor
RES DEV	Resource Developer
RC	Resource Coordinator
CC	Case Coordinator
AD	Administrative Officer
VON	
ED	Executive Director
AED	Assistant Executive Director
STCD	Short Term Care Director
SUP	Supervisor/Team Leader
HCC	Hospital Case Coordinator
HRN	Hospital Referral Nurse (a.k.a. Hospital Continuing Care Coordinator)
Region/VON	
BSN	Baccalaureate Nurse
RN	Diploma Nurse
LPN	Licensed Practical Nurse
HCA	Home Care Attendant (including orderlies)
HSW	Home Support Worker
SW	Social Worker

G2

EXTERNAL REVIEW CONTINUING CARE PROGRAM
REGIONAL/VON VISIT INTERVIEWS

DATE ________________ TIME _________________

REGION _________________________________

INTERVIEWER(S) ___________________________________

____

INTERVIEWEE(S)

(1) PRESENT POSITION TITLE	LENGTH OF SERVICE

(2) PREVIOUS POSITION TITLE/RESP.	LENGTH OF SERVICE

(3) EDUCATIONAL PREPARATION/TRAINING	GRADUATION YEAR

INTERVIEW QUESTIONS FOR ON-SITE
REGIONAL VISIT INTERVIEWS

QUESTIONS / STAFF INTERVIEWED	REGIONAL							VON						REGION/VON					
	RD	RCCC	SUP	RES DEV	RC	CC	AO	ED	AED	STC DIR	SUP	HCC	HRN	BSN	RN	LPN	HCA	HSW	SW
A) Program Scope and Mandate																			
1. What is the purpose of the continuing care program (CCP)? Has this changed over time? Explain.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. How does the program address this purpose? Has this changed over time? Are services still relevant?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3. Is the scope of the program clearly defined? in terms of who it is supposed to serve? under what conditions?	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓						
4. Is the scope and mandate open to alternative interpretations?	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓						
5. Where is the scope and mandate of the program documented? i.e. the policy manual? legislation?		✓	✓							✓	✓	✓	✓						
6. Do you have any comments/concerns regarding the CCP scope, mandate, objectives?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
B) Achievement of Program Objectives																			
1. What do you understand to be the objectives of the program in the sense of what it is supposed to accomplish?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. Are there any significant obstacles to it achieving its objectives?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3. What impact has the CCP had on the following? - clients? - family? - acute care hospital beds? - extended care beds? - personal care homes? - other community programs?	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4. In your opinion, what would happen if the CCP was non-existent?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

INTERVIEW QUESTIONS FOR ON-SITE
REGIONAL VISIT INTERVIEWS

QUESTIONS / STAFF INTERVIEWED	REGIONAL							VON						REGION/VON					
	RD	RCCC	SUP	RES DEV	RC	CC	AO	ED	AED	STC DIR	SUP	HCC	HRN	BSN	RN	LPN	HCA	HSW	S
C) Forecasting Demand And Utilization 1. The CCP has grown considerably since its inception. What factors account for this growth?	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓						
2. What are the internal and external (e.g. hospital closures, policy changes) factors affecting current service demand? What options are available to respond to these demands/pressures?	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓						
3. Describe how you would/do forecast service demand/utilization for your region? Are there seasonal variations?	✓	✓	✓		✓			✓	✓	✓	✓								
4. What would be helpful/facilitate your ability to forecast service demand?	✓	✓	✓		✓			✓	✓	✓	✓								
5. In your region, is there a waiting list/period for - the CCP? - hospital beds? - personal care home beds? Please provide examples as well as options available to address these waiting lists/periods.	✓	✓	✓					✓	✓	✓		✓	✓						
6. Do you have any comments/concerns regarding factors/methods used to forecast service demand and/or utilization.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

INTERVIEW QUESTIONS FOR ON-SITE
REGIONAL VISIT INTERVIEWS

QUESTIONS / STAFF INTERVIEWED	REGIONAL							VON						REGION/VON					
	RD	RCCC	SUP	RES DEV	RC	CC	AO	ED	AED	STC DIR	SUP	HCC	HRN	BSN	RN	LPN	HCA	HSW	SW
D) Expenditure Control																			
1. Describe the process by which your Home Care Assistance and Regional Operational budget is prepared; approved and managed. What is the involvement of OCC and Administrative service in the budget process?	✓	✓					✓	✓	✓	✓									
2. How are program dollars for CCP allocated and how does this differ from other provincial programs?	✓	✓					✓												
3. Describe the budget structure for your area. How are budgets for CCP operations and purchased services distinguished? At what levels are budgets disaggregated?	✓	✓					✓	✓	✓	✓									
4. Describe your role/responsibilities in relation to budget preparation, budget approval, budget management and budget control. To what degree is the budgeting process part of the management process?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓						
5. Are the guidelines/directions for budget preparation adequate? Are they clear, feasible to follow, sent to you on time? Is there any information you require for budget preparation that you lack? Are there opportunities for you to consult with relevant officials regarding budget preparation?	✓	✓					✓	✓	✓	✓									
6. What is your recourse if the budget submitted is not approved? Is this process exercised?	✓	✓					✓	✓	✓	✓									
7. How are budget variances addressed-monthly, annually? Are there incentives in place to ensure budget control? What are the consequences for you and your operational area if you exceed your budget?	✓	✓					✓	✓	✓	✓									
8. To what extent do you feel responsible for keeping program spending within budget limits? Are there conflicts involved in managing the program budget while also adhering to program eligibility criteria and maintaining CCP as an open ended program?	✓	✓	✓	✓		✓	✓	✓	✓	✓									
[illegible]cribe the budget/financial reports submitted, and [illegible]rated. [illegible] the reports adequate? i.e. accurate, timely, relevant, etc.? How is this information utilized in your region?	✓	✓	✓				✓	✓	✓	✓									
10. What is your training and/or experience relative to budget preparation and control? Is this adequate? What training would you like to see implemented?	✓	✓					✓	✓	✓	✓									

INTERVIEW QUESTIONS FOR ON-SITE
REGIONAL VISIT INTERVIEWS

QUESTIONS / STAFF INTERVIEWED	REGIONAL							VON						REGION/VON					
	RD	RCCC	SUP	RES DEV	RC	CC	AO	ED	AED	STC DIR	SUP	HCC	HRN	BSN	RN	LPN	HCA	HSW	
11. What is your CCP budget allocation for this year? Is this appropriate?																			
12. Do you have any comments/concerns regarding expenditure control of the CCP?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

INTERVIEW QUESTIONS FOR ON-SITE
REGIONAL VISIT INTERVIEWS

QUESTIONS / STAFF INTERVIEWED	REGIONAL							VON						REGION/VON					
	RD	RCCC	SUP	RES DEV	RC	CC	AO	ED	AED	STC DIR	SUP	HCC	HRN	BSN	RN	LPN	HCA	HSW	SW
E) Information Systems																			
1. What information systems presently exist for gathering data/information on - clients? - services provided? - program spending? - service providers? - program management?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓						
2. What data do you routinely collect at present? How is this information recorded/reported? Who uses the information and for what purpose?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓						
3. Describe the program information received from OCC. How is this data/information used in your Region?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓						
4. Do you experience difficulty accessing accurate information in a timely, manner? How does this affect program management? Provide examples.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
5. Is there information that is not presently collected that you would find valuable in providing cost-effective services? Provide examples.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
6. Do you have any comments/concerns regarding existing or future information systems for the CCP?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

INTERVIEW QUESTIONS FOR ON-SITE
REGIONAL VISIT INTERVIEWS

QUESTIONS / STAFF INTERVIEWED	REGIONAL							VON						REGION/VON					
	RD	RCCC	SUP	RES DEV	RC	CC	AO	ED	AED	STC DIR	SUP	HCC	HRN	BSN	RN	LPN	HCA	HSW	SW
F) Management Accountability and Coordination 1. Describe the relationship between the office for Continuing Care and regional CCP staff.	✓	✓	✓					✓	✓	✓	✓	✓							
2. Describe the organizational structure of the region and specifically the role and responsibilities of the CCP staff within the structure. Are job descriptions available?	✓	✓	✓	✓				✓	✓	✓	✓	✓							
3. What are the major responsibilities of your position? Are the tasks performed daily reflective of these responsibilities? Please provide examples. Are there any obstacles to exercising your responsibilities? Do you have any indicators on benchmarks that you use to judge your success in fulfilling your responsibilities? How is your job performance judged?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4. What mechanisms are there to monitor and report the operational performance of your group to higher organizational levels, e.g. annual program reviews, caseload reviews? program/professional standards.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
5. Do you have any comments/concerns regarding management accountability for program delivery and/or management's coordination of regional service delivery?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓						
6. How is your job performance judged? How often are appraisals completed? by whom? what input do you have? what appeal mechanisms exist?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

7

INTERVIEW QUESTIONS FOR ON-SITE
REGIONAL VISIT INTERVIEWS

QUESTIONS / STAFF INTERVIEWED	REGIONAL							VON						REGION/VON					
	RD	RCCC	SUP	RES DEV	RC	CC	AO	ED	AED	STC DIR	SUP	HCC	HRN	BSN	RN	LPN	HCA	HSW	SW
G) Role and Accountability of VON 1. Describe the role of VON within the CCP, specifically the reporting and/or coordination relationships with the OCC and the three Winnipeg regions.	✓	✓	✓			✓		✓	✓	✓	✓	✓	✓						
2. What mechanisms are in place to ensure VON adherence to program policies and procedures? Are there any inconsistencies between the CCP Manual and the VON manual?	✓	✓	✓					✓	✓	✓	✓	✓	✓						
3. What are the implications of VON holding both case management and service delivery functions for the short term care (STC) component of home care? Are there other feasible alternative arrangements?	✓	✓	✓					✓	✓	✓	✓		✓						
4. Describe the process of transferring cases between short term and long term care. How descriptive is this process for the client? family? case coordinators?		✓	✓		✓	✓				✓	✓	✓	✓						
5. What are the implications of HCC and HRN initiating the service plan for approximately 50% of the Long Term Cases (LTC) and at the same time reporting to VON?		✓	✓			✓		✓	✓	✓	✓	✓	✓						
5. Do you have any comments/concerns regarding VON's role within the CCP?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

INTERVIEW QUESTIONS FOR ON-SITE
REGIONAL VISIT INTERVIEWS

QUESTIONS / STAFF INTERVIEWED	REGIONAL							VON						REGION/VON					
	RD	RCCC	SUP	RES DEV	RC	CC	AO	ED	AED	STC DIR	SUP	HCC	HRN	BSN	RN	LPN	HCA	HSW	
H) Service Coordination																			
1. Describe the relationship between the CCP regional staff and the following: - hospitals - personal care homes - VON - community agencies (meals on wheels etc) - other government programs (i.e. Child and family services, (e.g. welcome home) and Manitoba Health Services Commission (e.g. adult day care, respite care) - service provider groups	✓	✓	✓			✓		✓	✓	✓		✓	✓	✓	✓	✓			✓
2. What mechanisms or organizational linkages (e.g. committees, referral systems, shared staff, reporting) are entailed in these relationships?	✓	✓						✓	✓	✓		✓	✓						
3. What are the major service coordination strengths of the CCP? The major weaknesses? service gaps? What options are available to address weaknesses and/or gaps? Are there any obstacles to achieving service coordination?	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓			✓
4. Are there any examples of inadequate service coordination? What are the implications of such inadequencies for clients, families, CCP and other services?	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓			✓
5. Do you have any comments/concerns regarding service coordination in your region? within the CCP?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

INTERVIEW QUESTIONS FOR ON-SITE
REGIONAL VISIT INTERVIEWS

QUESTIONS / STAFF INTERVIEWED	REGIONAL							VON						REGION/VON					
	RD	RCCC	SUP	RES DEV	RC	CC	AO	ED	AED	STC DIR	SUP	HCC	HRN	BSN	RN	LPN	HCA	HSW	SW
I) Service Delivery Staffing 1. What guideline and directions do you have concerning the assignment of staff level and mix of staff used to deliver services? Are these appropriate? Do you adhere to them? Are there any problems/obstacles to implementing them? To what degree does the case type us staff availability determine the level of service provides and/or frequency and length of service.		✓	✓	✓		✓		✓	✓	✓	✓	✓	✓						
2. Describe the advantages and disadvantages associated with the utilization of professional and non-professional staff for service delivery in your region? Are there any staffing trends emerging? What are the costs associated with the various types of staff? Are there any constraints on using any categories of staff?		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓						
4. Describe the advantages and disadvantages associated with the utilization of different professionals e.g. nursing and social work; and with the utilization of different levels within a profession, e.g. BSN, RN, LPN.		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓			✓
5. Of the non-professional staff, (HCA, HSW) is there one group of workers who are utilized more frequently? Please provide explanation. How do staff differentiate the tasks performed by these two groups?		✓	✓	✓	✓	✓						✓	✓						
6. Do you have any comments/concerns regarding the mix and deployment of direct service staff of the Home Care Program in your region? Within the CCP?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

INTERVIEW QUESTIONS FOR ON-SITE REGIONAL VISIT INTERVIEWS

QUESTIONS / STAFF INTERVIEWED	REGIONAL							VON							REGION/VON					
	RD	RCCC	SUP	RES DEV	RC	CC	AO	ED	AED	STC DIR	SUP	HCC	HRN	BSN	RN	LPN	HCA	HSW	SW
J) Intake/Assessment/Panelling																			
1. How do private citizens learn of CCP services? How would they find out the telephone # of CCP? Who in your region answers these initial calls and what information is provided to clients? If someone other than client/family calls, is this handled differently?		✓		✓		✓				✓		✓	✓						
2. Describe the process by which a client accesses the CCP in your region? Is this effective? efficient? Are there methods to streamline this process? Please describe. What assurance is there that all clients requiring services will be seen by the program?		✓	✓			✓				✓	✓	✓	✓						
3. Who is involved in conducting the initial client assessment to determine program eligibility? What are the advantages and disadvantages of this method? What options are available to address the disadvantages? Are there ways to streamline the assessment process. Please describe.		✓	✓			✓				✓	✓		✓						
4. What are the major strengths and weaknesses of the Panelling process in your region? How would you address the weaknesses? How would you support the strengths?		✓	✓			✓				✓	✓		✓						
5. To what degree does the program guidelines address the the decision making at the intake, assessment, service provision and panelling stages? What mechanisms exist to ensure that appropriate decisions are made at these level?		✓	✓			✓				✓	✓	✓	✓						
6 Do you have any comments/concerns regarding the intake/assessment/panelling processes in your region? within the CCP?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

INTERVIEW QUESTIONS FOR ON-SITE
REGIONAL VISIT INTERVIEWS

QUESTIONS / STAFF INTERVIEWED	REGIONAL							VON							REGION/VON					
	RD	RCCC	SUP	RES DEV	RC	CC	AO	ED	AED	STC DIR	SUP	HCC	HRN	BSN	RN	LPN	HCA	HSW	SW
K) Staffing Workloads 1. What are the program caseload/workload standards for your type of region for case coordinators and resource coordinators? Is it appropriate? Explain.			✓	✓	✓	✓					✓	✓	✓	✓	✓	✓	✓	✓	✓
2. What is your present caseload/workload? Is this effective? efficient? Why are actual caseloads different from the standards? What are the obstacles to achieving the standards?		✓	✓	✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3. How are the following defined in your region: - large caseload - heavy caseload - heavy workload What measures are used to determine the above?		✓	✓	✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4. Describe the implications of a large and/or heavy caseload/workload for: - clients - service providers - program service delivery - management staff Are there any reports/documents to support your comments?		✓	✓	✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
5. Do you use any measures, other than caseload, to measure staff workload? Can you think of any additional measures that might be relevant? How do you measure the effectiveness, efficiency and productivity of the staff and service providers? Are there any other methods you would utilize?		✓	✓	✓	✓	✓				✓	✓	✓	✓						
6. In your region, what is the ratio of supervisors to staff/case coordinators? Is this effective? efficient? what are the implications of this ratio for: - management staff? - program service delivery?		✓	✓	✓						✓	✓								
7. How does the professional background of the supervisor impact their ability to supervise other professionals (e.g. nursing and social work)?		✓	✓		✓					✓	✓	✓	✓						
8. How do you access your superior if you have questions/concerns? Is this effective? sufficient?		✓	✓	✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

INTERVIEW QUESTIONS FOR ON-SITE
REGIONAL VISIT INTERVIEWS

QUESTIONS / STAFF INTERVIEWED	REGIONAL							VON						REGION/VON					
	RD	RCCC	SUP	RES DEV	RC	CC	AO	ED	AED	STC DIR	SUP	HCC	HRN	BSN	RN	LPN	HCA	HSW	
9. How are service requests allocated amongst the service providers? Please describe the strengths and weaknesses of the process. What options are available to deal with weaknesses? Are there methods to ensure equitable workloads amongst the available service providers? Please describe. To what degree is the same worker assigned to one client for the duration of service?			✓	✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
10. Do you have any comments/concerns regarding the past, present or future staff workloads in your region? within the CCP?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

INTERVIEW QUESTIONS FOR ON-SITE
REGIONAL VISIT INTERVIEWS

QUESTIONS / STAFF INTERVIEWED	REGIONAL							VON						REGION/VON					
	RD	RCCC	SUP	RES DEV	RC	CC	AO	ED	AED	STC DIR	SUP	HCC	HRN	BSN	RN	LPN	HCA	HSW	SW
L) Client Servicing																			
1. In your opinion, do clients receive adequate servicing (type and length) by appropriate staff? explain.		✓	✓	✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. Have client demands for services/service providers changed over time? Have client needs for services/service providers changed over time? How have family needs/demands changed over time? Explain using examples if possible.		✓	✓	✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3. Are there any services presently housed within the CCP that may be appropriately structured within another program? Explain.		✓	✓			✓				✓	✓	✓	✓						
4. Are there any programs/services structured within government/others that could or should be housed within the CCP? Explain.		✓	✓	✓	✓	✓				✓	✓	✓	✓						
5. Are you aware of any gaps in client services? Provide examples please.		✓	✓	✓	✓	✓				✓	✓	✓	✓						
6. Is there any indication that clients are receiving too much services, or receiving services for too long? What data do you collect on the volume, mix and duration of client services?		✓	✓	✓	✓	✓				✓	✓	✓	✓						
7. How difficult is it to decrease client services after they have been on the program for a length of time? What options are available to address this?					✓	✓				✓	✓	✓	✓						
8. What procedures or mechanisms do you follow to ensure that clients receive the appropriate level of services? Do you ever receive complaints from clients about the type of service provides? Please describe them? To what extent are you able to respond to them?		✓	✓	✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
9. How much time is involved in authorizing client services and how much time is spent investigating descrepancies between client and providers. How can this be reamlined?				✓	✓	✓						✓	✓	✓	✓	✓	✓	✓	✓
you have any concerns/comments regarding client servicing in your region? Within the CCP?	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

INTERVIEW QUESTIONS FOR ON-SITE
REGIONAL VISIT INTERVIEWS

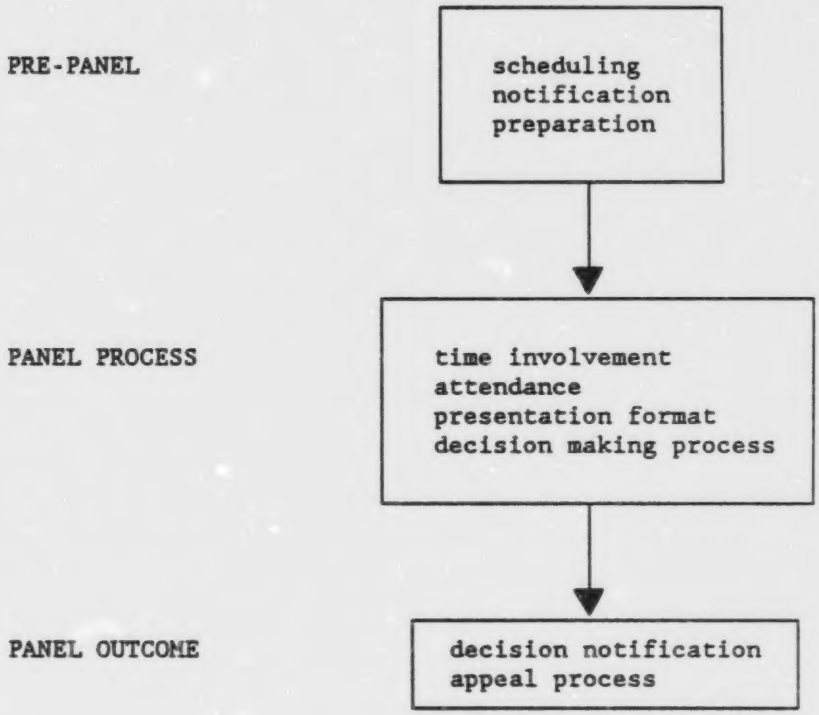
QUESTIONS / STAFF INTERVIEWED	REGIONAL							VON						REGION/VON					
	RD	RCCC	SUP	RES DEV	RC	CC	AO	ED	AED	STC DIR	SUP	HCC	HRN	BSN	RN	LPN	HCA	HSW	
M) Special Needs Populations																			
1. To what extent are people with special needs served in your region? Please describe these clients and their needs. How is CCP meeting their needs? what difficulties does this create for CCP?	✓	✓	✓	✓				✓	✓	✓									
2. Describe the past, present and future implications for the CCP relative to these special needs populations. How are these populations served by CCP? How are they served by other programs? What is done to coordinate CCP with other programs. What options are available to serve these groups? Should they be served by special teams within CCP?	✓	✓	✓	✓				✓	✓	✓									
3. Do you have any concerns/comments regarding special needs populations in your region? within the CCP? Do you have any concerns about the appropriateness of CCP for such special needs clients.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
N) Staff Training																			
1. Describe the education, experience and training you have received to prepare you for your present position? Was this sufficient?	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. Identify the qualifications and skills necessary to effectively carry out your role.	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3. Do you have any difficulty attracting or retaining suitable and well qualified staff? If yes, please elaborate. What are the regional plans for staff orientation, training, in service education?	✓	✓	✓	✓	✓			✓	✓	✓	✓								
4. Do you have any comments/concerns regarding staff training in your region? Within the CCP?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
O) Job Satisfication																			
1. What makes your job satisfying? dissatisfying?		✓	✓	✓	✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓

APPENDIX H

PANEL REVIEW GUIDE

APPENDIX H

PANELLING PROCESS
OBSERVATION GUIDE FRAMEWORK


PRE-PANEL
scheduling
notification
preparation
PANEL PROCESS
time involvement
attendance
presentation format
decision making process
PANEL OUTCOME
decision notification
appeal process

PANELLING PROCESS
OBSERVATION/QUESTION GUIDE

1. Panel Scheduling

   - who's involved? what is their contribution?
   - how are panels scheduled?
   - when are they scheduled?
   - time involved in scheduling?
   - location of meeting?
   - max/min no. clients each session?
   - agenda set?

2. Client/Family/Staff Notification

   - who notifies individuals that they are going to be panelled? and when?
   - how are individuals notified?
   - when are they notified?

3. Case/Staff Preparation

   - why is case going to panel? what type of assessment is done in advance?
   - who's involved? what is their contribution?
   - how is case prepared? is the case prepared differently if the client is from the hospital vs the community? how?
   - when is case prepared for panel?
   - how much time is involved is case preparation? (preparing family and paper work)
   - topics and information covered - to what extent are clients', families' and others' views recorded?
   - what recommendations are made and how are they justified?

4. Time Involvement

   - time spent waiting to present case to panel?
   - length of meeting?
   - time spent on each case?

5. Attendance

   - who's present?
   - who is usually present?
   - do all individuals stay for entire length of meeting?
   - frequency of times where both nurse and social worker attend and rationale for some?

6. Presentation Format

- who presents cases?
- what information/data is presented?
- what format is used to present case information?
- what forms/reports are utilized?
- are clients and families consulted?

7. Decision Making Process

- what criteria/guidelines are utilized to reach decision?
- who is involved in making panel decision?
- how much time is spent on reaching decision?
- what style of decision making is utilized (consensus, majority vote)?
- to what extent are the views of clients and families/ significant others considered?
- how does the clients preference for a particular P.C.H. influence the decision-making process.
- how are conflicts/disagreements resolved?
- what is done to justify the decision or document
- what other alternatives were discussed?

8. Decision Notification

- who is notified of panel decision?
- what forms/reports generated
  - from a positive decision?
  - from a negative decision?
  - from a deferral?
- what is staff involvement in notification process?
- how much time is spent in notifying individuals of panel decisions?
- what type of information is reported on decision?
- who records panel decisions? how?

9. Appeal Process

- who informs clients/staff of appeal process?
- what information is presented to clients regarding appeals?
- how are deferrals/referrals handled?
- why do clients/staff appeal decisions?

10. Other

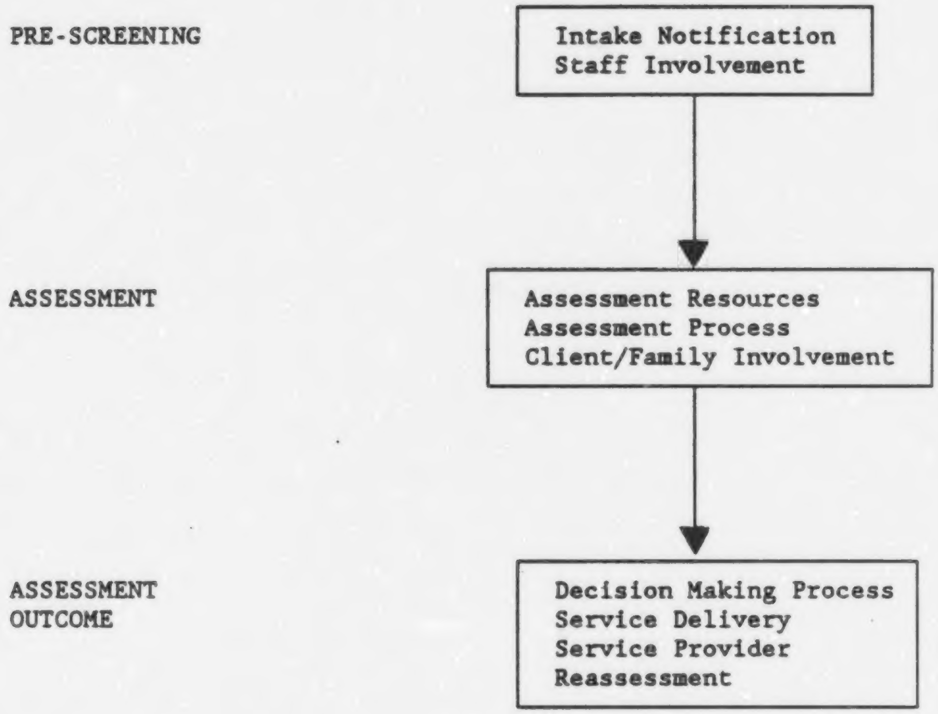
- determine cost of panel process (e.g. salary x individuals x time involved)
- if client requires more care than is possible in a PCH, what occurs?
- how do referrals to extended treatment units occur?
- if patient's were not given a preference, but simply placed in the first PCH available, what wo[illegible]e the impact on the waiting list?
- what medical input occurs during the panelling process?

APPENDIX I

INTAKE REVIEW GUIDE

APPENDIX I

INTAKE/ASSESSMENT
OBSERVATION GUIDE FRAMEWORK


PRE-SCREENING
Intake Notification
Staff Involvement
ASSESSMENT
Assessment Resources
Assessment Process
Client/Family Involvement
ASSESSMENT OUTCOME
Decision Making Process
Service Delivery
Service Provider
Reassessment

INTAKE/ASSESSMENT
OBSERVATION/QUESTION GUIDE

1. Intake Notification

    - what hours of the day/days of the week are the public able to call? how is the phone # advertised?
    - what is the source of referral?
    - who receives initial requests for service?
    - what information is obtained from referral source?
    - what is the range of time period between referral and assessment? usual time?
    - how are calls/referrals screened for appropriateness? (e.g. program eligibility)?
    - how does the intake process differ from an initial assessment?
    - how does the intake process differ between VON transfer, community and hospital discharged clients?

2. Staff Involvement

    - how are staff informed of potential new cases (new to staff and new to program?)
    - how are new cases defined? assigned for assessment?
    - who is involved in setting up initial meetings with family/client? (hospital, VON, community)?
    - how much time is involved in establishing and setting up contact with client?

3. Assessment Resources

    - who participates in assessment process?
    - who participated in this assessment?
    - how much time is spent with client/family/referral source/external agencies?

4. Assessment process

    - what type of assessment is conducted (e.g. functional health, psychological, social, physical)?
    - who conducts the above assessment? what is their professional background? experience?
    - what information/data is required of family? client? external agency?
    - what reports/forms are completed during assessment?
    - what criteria/guidelines/principles are utilized during assessment process?
    - how much time is involved in the assessment process?

5. Client/Family involvement

   - what program information is shared with family/client? written? verbal? at what point of contact (hospital, VON community assessment)?
   - is the client given instructions on what to do if problems arise during working hours? after hours?
   - what program questions/comments does client/family ask/make?

6. Decision Making Process

   - what criteria/guidelines/principles are utilized to arrive at a decision for program acceptance?
   - what reports/forms are generated from a positive decision? negative response?
   - how is case coordination decided?
   - what is involved if client does not meet eligibility criteria?
   - how much time is involved in reaching decision outcome?
   - how is client/family notified of decision?

7. Service Delivery

   - what criteria are used to determine type of service delivery? frequency of service delivery?
   - what reports/forms are generated?
   - what is the range of time and the usual time that different services are started after assessment?
   - which services need to be started more quickly and what factors (if any) inhibit this?
   - what information is supplied to client/family?
   - what questions do family/client ask?

8. Service Provider

   - what criteria are used to determine level of service provider? frequency of service?
   - what reports/forms are generated?
   - what information is supplied to client/family?
   - what questions do family/client ask?

9. Reassessment

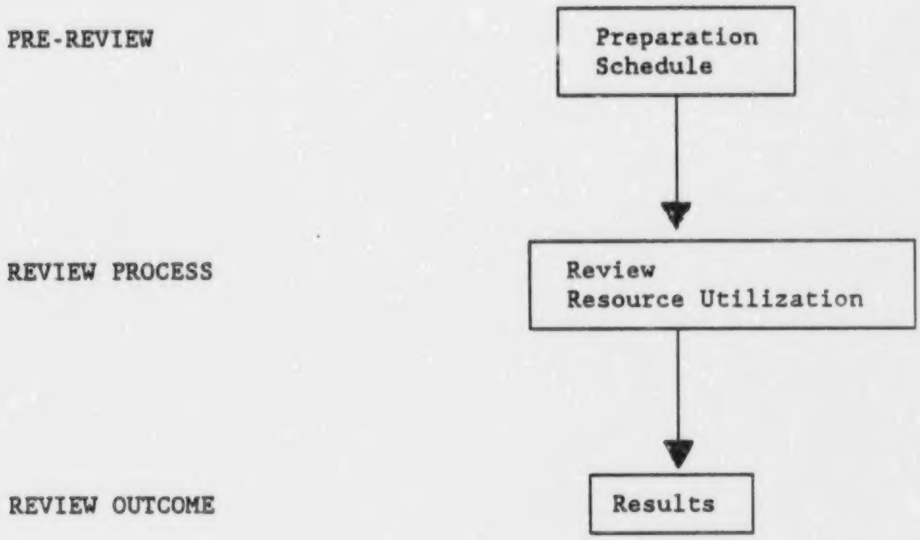
   - when is reassessment scheduled?
   - who is involved in reassessments?
   - how frequently are reassessments performed?
   - how is the frequency of reassessment determined?
   - what is the outcome of reassessment?
   - what % of cases are reassessed with what frequency?

APPENDIX J

CASE REVIEW GUIDE

APPENDIX J

CASE REVIEW
OBSERVATION GUIDE FRAMEWORK


PRE-REVIEW
Preparation
Schedule
REVIEW PROCESS
Review
Resource Utilization
REVIEW OUTCOME
Results

CASE REVIEW
OBSERVATION/QUESTION GUIDE

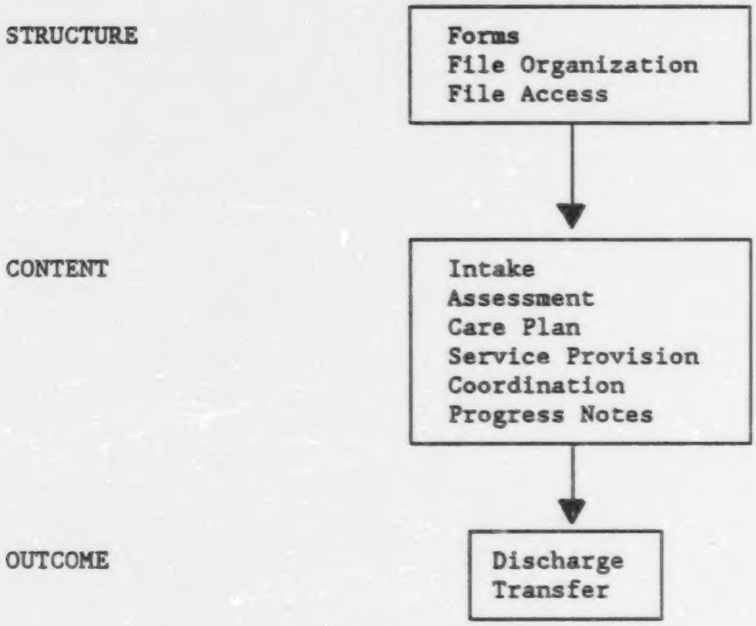
1. Case Review Preparation
    - who needs to be involved in review?
    - what forms/reports are necessary to review case?
2. Case Review Scheduling
    - what criteria/guidelines are utilized to determine case review priorities?
    - how often is case review scheduled? how is this decided?
    - who determines the frequency? how is this decided?
    - how much time is spent in reviewing one case?
    - how much time is spent reviewing cases weekly? monthly?
    - how many cases are likely to be scheduled for review weekly? monthly?
3. Case Review Resources
    - who is actually involved in reviewing cases? (e.g. supervisor, client)?
    - if one discipline is involved in reviewing another discipline how does this work?
    - how much time is actually spent on reviewing/case?
4. Case Review Process
    - what is reviewed?
    - how are cases reviewed (e.g. format)?
    - what method is used to review case (telephone, direct, 3rd party caregivers, on-site)?
    - what criteria/guidelines are utilized during the review?
5. Case Review Results
    - what is the usual outcome of case review? for the client? service provider?
    - what forms/reports are generated?
    - who is notified of review results?
    - what forms/reports are generated?
    - who is notified of review results?

APPENDIX K

CLIENT FILE REVIEW GUIDE

APPENDIX K

CLIENT FILE REVIEW GUIDE
FRAMEWORK


STRUCTURE
Forms
File Organization
File Access
CONTENT
Intake
Assessment
Care Plan
Service Provision
Coordination
Progress Notes
OUTCOME
Discharge
Transfer

CLIENT FILE REVIEW GUIDE

1. Forms
    - identify all formal (provincial) and informal (regional specific) forms, tables, charts etc. used and their purpose.
    - Is there any duplication of information between forms?
2. File Organization
    - how is the client file organized? is there a standard in effect?
    - where are pertinent facts recorded (allergies etc)?
    - are all files organized similarly?
    - are files subdivided? separated? for what purpose?
    - are new and old files organized similarly?
    - is current client information easy to access?
    - is there more than one file for keeping information re client (e.g. service information)?
3. File Access
    - where are current client files kept? Can they leave the office?
    - how are they organized (e.g. alphabetic, current, region, case coordinator etc.)
    - who has access to client files? who keeps track of where total client file is located?
    - where are past files kept? are they easy to access?
    - is there an easy way to access key client information (e.g. file card box, rotary wheel)? how is this information used?
4. Intake
    - What information is collected? adequate?
    - what form is used? is this adequate?

5. Assessment

- who conducted the assessment? at what point of entry?
- what type of assessment is documented? (biological, psychological, social, cultural)
- what type of medical input is involved?
- how is the client risk established/identified/documented.
- is the assessment adequate to determine eligibility for CCP?
- is the family physician's name listed? is the physician notified/contacted? how often?
- how is client/family involvement documented?
- how are client needs identified, by whom, and what action is taken?
- how frequent are reassessments?
- what was the date of the last case review?

6. Care Plan

- are care plans documented? adequate? current?
- are goals, realistic? clear? appropriate?
- is attention given to rehabilitation, increasing independence "self-care"?
- how is family/client involvement documented?
- is continuity of care between service providers evident?
- how frequent are revision, updates? how are partial reviews documented?
- what types of revisions are made?
- is information easy to read i.e. shorthand, abbreviations clear?
- what is the frequency of service provision increase/decreases? what rationale is provided?
- how often is level of service provider changed? (i.e. RN, LPN. HCA) is rationale evident?

7. Service Provision

- appropriate type of services authorized based on client need and family involvement? (RN SW LPN HSW HCA)
- frequency and spacing of visits appropriate in relation to client and family needs?
- level of provider assigned considers client safety, program economics, client goal attainment skill level and training?
- how are medical orders handled? (assessment, care plan, service provider level and frequency, care evaluation and documentation)

8. Coordination of Community Services (Internal & External)

- how are internal available resources documented? coordinated? (e.g. family, community, volunteers etc.)
- how are external services authorized, coordinated and communicated between disciplines (e.g. care plans, team conference)

9. Progress notes

- who has progress notes? - for what purpose?
- how are they integrated? what is the format used (e.g. soap)?
- is client condition and progress apparent? current?

10 Discharge

- how is client discharge from home care documented?
- was discharge appropriate? justified?
- is there documentation of assistance to client/family for discharge plans/follow-up.
- can intake and discharge be linked?
- is some approximation of duration of service documented at intake and does this correlate with the length of time during which the client is with the program?

11. Transfer

- what information is collected for transfer of coordination from region - region, and STC to LTC, hospital to government? is there duplication of information recorded?

- how is family/client involvement in transfer documented?

12. Close

- how is client file closed? what information is recorded? by whom?

APPENDIX L

PHASE TWO - REGIONAL/VON VISIT INTERVIEW GUIDE

APPENDIX L

INTERVIEW QUESTIONS FOR 7 REGIONAL VISITS

EXTERNAL REVIEW - CONTINUING CARE PROGRAM
REGIONAL VISIT INTERVIEW GUIDE

INTERVIEW LEGEND

REGIONAL

RD	Regional Director
RCCC	Regional Continuing Care Coordinator
SUP	Area/Program
RES DEV	Resource Developer
RC	Resource Coordinator
CC	Case Coordinator
AO	Administrative Officer

Abbreviations

HCC	Hospital Case Coordinator
HRN	Hospital Referral Nurse
CCP	Continuing Care Program

L2

EXTERNAL REVIEW CONTINUING CARE PROGRAM
REGIONAL VISIT INTERVIEWS

DATE ______________ TIME ______________

REGION ______________________________

INTERVIEWER(S) ______________________________

____

INTERVIEWEE(S)

(1) PRESENT POSITION TITLE	LENGTH OF SERVICE
____________________	________________
____________________	________________
____________________	________________
____________________	________________

(2) PREVIOUS POSITION TITLE/RESP.	LENGTH OF SERVICE
____________________	________________
____________________	________________
____________________	________________
____________________	________________

(3) EDUCATIONAL PREPARATION/TRAINING

____

____

____

____

INTERVIEW QUESTIONS FOR ON-SITE
REGIONAL VISIT INTERVIEWS

QUESTIONS / STAFF INTERVIEWED	REGIONAL VISIT						
	RD	RCCC	SUP	RES DEV	RC	CC	AO
A) Program Scope and Mandate 1. Is the scope of the program clearly defined? in terms of who it is supposed to serve? under what conditions?		✓	✓	✓	✓	✓	
2. Is the scope and mandate open to alternative interpretations?		✓	✓		✓	✓	
B) Achievement of Program Objectives 1. Are there any significant obstacles to Achieve the program objectives?		✓	✓		✓	✓	
C) Forecasting Demand And Utilization 1. Describe how you would/do forecast service demand/utilization for your region? Are there seasonal variations?		✓	✓			✓	
2. What would be helpful/facilitate your ability to forecast service demand?		✓	✓			✓	
D) Expenditure Control 1. Describe the process by which your Home Care Assistance and Regional Operational budget is prepared; approved and managed. What is the involvement of OCC and Administrative service in the budget process?	✓	✓					✓
2. How are program dollars for CCP allocated and how does this differ from other provincial programs?	✓						
3. Describe your role/responsibilities in relation to budget preparation, budget approval, budget management and budget control. To what degree is the budgeting process part of the management process?	✓	✓					✓
4. Are the guidelines/directions for budget preparation adequate? Are they clear, feasible to follow, sent to you on time? Is there any information you require for budget preparation that you lack? Are there opportunities for you to consult with relevant officials regarding budget preparation?	✓	✓					✓
5. How are budget variances addressed-monthly, annually? Are there incentives in place to ensure budget control? What are the consequences for you and your operational area if you exceed your budget?	✓	✓					✓

INTERVIEW QUESTIONS FOR ON-SITE
REGIONAL VISIT INTERVIEWS

QUESTIONS / STAFF INTERVIEWED	REGIONAL VISIT						
	RD	RCCC	SUP	RES DEV	RC	CC	AO
6. To what extent do you feel responsible for keeping program spending within budget limits? Are there conflicts involved in managing the program budget while also adhering to program eligibility criteria and maintaining CCP as an open ended program?	✓	✓					
7. Describe the budget/financial reports submitted, and generated. Are the reports adequate? i.e. accurate, timely, relevant, etc.? How is this information utilized in your region?	✓	✓					✓
8. What is your training and/or experience relative to budget preparation and control? Is this adequate? What training would you like to see implemented?	✓	✓					✓
9. What is your Home Care Assistance and Regional Operations budget allocation for this year? Is this appropriate?	✓	✓					✓
E) Information Systems 1. What data do you routinely collect at present? How is this information recorded/reported? Who uses the information and for what purpose?		✓	✓	✓	✓	✓	
2. How is the program information received from CCC. used in your Region?		✓		✓			
3. Do you experience difficulty accessing accurate information in a timely, manner? How does this affect program management? Provide examples.		✓					
4. Is there information that is not presently collected that you would find valuable in providing cost-effective services? Provide examples.		✓	✓	✓	✓	✓	✓
F) Management Accountability and Coordination 1. Describe the role of CCC and their relationship with REgional CCP staff.	✓	✓	✓	✓		✓	
2. Describe the organizational structure of the region and specifically the role and responsibilities of the CCP staff within the structure. Are job descriptions available?	✓	✓					
3. What are the major responsibilities of your position? Are the tasks performed daily reflective of these responsibilities? Please provide examples. Are there any obstacles to exercising your responsibilities? Do you have any indicators on benchmarks that you use to judge your success in fulfilling your responsibilities? How is your job performance judged?	✓	✓	✓	✓	✓	✓	✓

INTERVIEW QUESTIONS FOR ON-SITE
REGIONAL VISIT INTERVIEWS

QUESTIONS / STAFF INTERVIEWED	REGIONAL VISIT						
	RD	RCCC	SUP	RES DEV	RC	CC	AO
4. How is your job performance judged? How often are appraisals completed? by whom? what input do you have? what appeal mechanisms exist?		✓	✓	✓	✓	✓	
5. What mechanisms are there to monitor the operational performance of the groups reporting to you. e.g. annual program reviews, caseload reviews program/professional standards?	✓	✓	✓	✓	✓		
G) Role and Accountability of VON 1. Describe the role of VON within the CCP, specifically the reporting and/or coordination relationships with the OCC and the three Winnipeg regions.	✓	✓	✓			✓	
2. What are the implications of VON holding both case management and service delivery functions for the short term care (STC) component of home care? Are there other feasible alternative arrangements?		✓	✓			✓	
3. Describe the process of transferring cases between short term and long term care. How disruptive is this process for the client? family? case coordinators?		✓	✓			✓	
4. What are the implications of HCC and HRN initiating the service plan for approximately 50% of the Long Term Cases (LTC) and at the same time reporting to VON?		✓	✓			✓	
H) Service Coordination 1. Are there any examples of inadequate service coordination? /service gaps? What are the implications of such inadequencies/gaps for clients, families, CCP and other services?	✓	✓					
I) Service Delivery Staffing 1. What guidelines and directions do you have concerning the assignment of staff level and mix of staff used to deliver services? Are these appropriate? Do you adhere to them? Are there any problems/obstacles to implementing them?		✓	✓			✓	
2. To What extent do you consider the following when determining and/or assigning staff? Staff - costs Client - needs - skills - risk - experience - culture - seniority - complaints - culture - location				✓	✓	✓	

INTERVIEW QUESTIONS FOR ON-SITE
REGIONAL VISIT INTERVIEWS

QUESTIONS / STAFF INTERVIEWED	REGIONAL VISIT						
	RD	RCCC	SUP	RES DEV	RC	CC	AC
3. To what degree do the Case Coordinators provide direct client service? Please elaborate on the type and frequency of service delivery.		✓	✓			✓	
J) Intake/Assessment/Panelling							
1. Describe the process by which a client accesses the CCP in your region? Is this effective? efficient? Are there methods to streamline this process? Please describe. What assurance is there that all clients requiring services will be seen by the program?		✓				✓	
2. Who is involved in conducting the initial client assessment to determine program eligibility? What are the advantages and disadvantages of this method? What options are available to address the disadvantages? Are there ways to streamline the assessment process. Please describe.		✓	✓			✓	
3. What are the major strengths and weaknesses of the Panelling process in your region? How would you address the weaknesses? How would you support the strengths?		✓	✓			✓	
4. To what degree does the program guidelines address the the decision making at the intake, assessment, service provision and panelling stages? What mechanisms exist to ensure that appropriate decisions are made at these levels?		✓	✓	✓		✓	
K) Staffing Workloads							
1. What is your present caseload/workload? Is this effective? efficient? Why are actual caseloads different from the standards? What are the obstacles to achieving the standards?		✓	✓		✓	✓	
2. Describe the implications of a large and/or heavy caseload/workload for: - clients - service providers - program service delivery - management staff Are there any reports/documents to support your comments?		✓			✓	✓	
3. Do you use any measures, other than caseload, to measure staff workload? Can you think of any additional measures that might be relevant? How do you measure the effectiveness, efficiency and productivity of the staff and service providers? Are there any other methods you would utilize?		✓				✓	

INTERVIEW QUESTIONS FOR ON-SITE
REGIONAL VISIT INTERVIEWS

QUESTIONS / STAFF INTERVIEWED	REGIONAL VISIT						
	RD	RCCC	SUP	RES DEV	RC	CC	AO
4. In your region, what is the ratio of supervisors to staff/ case coordinators? Is this effective? efficient? what are the implications of this ratio for: - management staff? - program service delivery?			✓	✓	✓		
5. How does the professional background of the supervisor impact their ability to supervise other professionals (e.g. nursing and social work)?		✓	✓			✓	
6. How are service requests allocated amongst the service providers? Please describe the strengths and weaknesses of the process.				✓	✓	✓	
L) Client Servicing 1. Have client demands for services/service providers changed over time? Have client needs for services/service providers changed over time? How have family needs/demands changed over time? Explain using examples if possible.	✓	✓	✓			✓	
2. Are you aware of any gaps in client services? Provide examples please.	✓	✓					
3. Is there any indication that clients are receiving too many services, or receiving services for too long? What data do you collect on the volume, mix and duration of client services?		✓	✓	✓	✓	✓	
4. How difficult is it to decrease client services after they have been on the program for a length of time? What options are available to address this?			✓			✓	
5. How difficult is it to decrease client services for clients in your home community? What options are available to deal with this?			✓			✓	
6. What procedures or mechanisms do you follow to ensure that clients receive the appropriate level of services? Do you ever receive complaints from clients about the type of service provides? Please describe them? To what extent are you able to respond to them?			✓			✓	
M) Special Needs Populations 1. Do you have any concerns/comments regarding special needs populations (e.g. MR, Psychiatry, Adult disabled, Children) in your region? within the CCP? Do you have any concerns about the appropriateness of CCP for such special needs clients.	✓	✓	✓				

INTERVIEW QUESTIONS FOR ON-SITE
REGIONAL VISIT INTERVIEWS

QUESTIONS / STAFF INTERVIEWED	RD	REGIONAL VISIT					
		RCCC	SUP	RES DEV	RC	CC	AD
N) Staff Training 1. Has your education, experience and training prepared you for your present position? Identify the qualifications and skills necessary to effectively carry out your role.		✓	✓	✓	✓	✓	
2. Do you have any difficulty attracting or retaining suitable and well qualified staff? If yes, please elaborate. What are the regional plans for staff orientation, training, in service education?	✓	✓	✓	✓	✓		
3. Do you have any comments/concerns regarding staff training in your region? Within the CCP?		✓	✓	✓	✓	✓	
O) Job Satisfication 1. What makes your job satisfying? dissatisfying?		✓	✓	✓	✓	✓	

APPENDIX M

REVIEW SOURCE DOCUMENTS

APPENDIX M

DOCUMENTS REVIEWED

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APPENDIX N

REGIONAL VARIATIONS

APPENDIX N

Regional Variations

The tables on page N-25 to N-54 depict the regional frequencies of the data collected during the client survey. The sample size for each region is indicated in brackets following the region title. Because cell frequencies were less than five in more than 20% of the expected cell frequencies, statistical significances using the chi-square test of independence will not be reported. Neither will all regional variations be reported in the text of this appendix. Rather, only those variations that appear to have clinical significance will be mentioned.

The Appendix is organized by the 10 regions. Each region is discussed highlighting any demographic or service trends. This is followed by a brief discussion of regional variations in general.

Westman (n=79)

Westman is serving a client population that is predominately:

. English (93%);
. female (65%) and elderly (86% over 65 years);
. house dwellers (66%);
. widowed (42%) or single (17%);
. without family in the same city (49%); and,
. living alone (47%) or with individuals who are healthy (67%) and do not work outside the home (76%).

Further, Westman clients reported that they:

. valued their homemaking service (43%);
. did not need additional Program services;
. needed the majority of services they currently received;
. did not need the RN and LPN nursing services they currently received (29% and 50% respectively);

- rated the services as excellent (48%) or good (47%);
- did not have concerns regarding the Program (94%);
- learned of the complaint process from program staff (52%); and,
- would contact program staff to register service complaints (88%).

As for the impact of the Program, had home care not been available when they first contacted the Program, 89% of the Westman clients, who would not have moved, reported that they would have managed, using their own resources. Of those who would have moved, 52% would have moved to a Personal Care Home.

Today, if service limits were established, 67% of Westman clients would manage on their own (a high percentage willing to pay for the service). Of those who would move because of service limits, 88% would move into a Personal Care Home.

In summary, Westman region may need to provide more support services than other regions due to the high percentage of elderly clients without family close by. It is also possible that clients currently receiving nursing services are over serviced (it is important to note that clients may not be the most appropriate individuals to determine their need for professional services).

Finally, although Westman clients are satisfied with their service, they appear to be quite capable of managing their own care if service limits were established. These data further suggest over servicing in the Westman region.

Eastman (n=70)

Eastman is basically serving a client population that:

- is culturally mixed - English 57%, French 14%, German 20% and Ukrainian 4%;
- is female (67%) and elderly (79% over 65);

- lives in both elderly persons housing units (36%) and houses (54%);
- is married (44%) or widowed (42%);
- has family living in their city (79%); and
- lives with others (69%) who are healthy (64%) and do not work outside the home (59%).

Eastman clients also reported that they:

- value their homemaking (41%) and personal care attendant (26%) service;
- do not require additional Program services;
- do not require current RN nursing services (21%), equipment services (40%), or supplies/dressing (20%);
- rated the Program services as excellent (46%) or good (44%);
- learned of the complaint process from program staff (70%) and would contact program staff with a service complaint (79%); and,
- did not have any concerns regarding the Program (97%).

As for the impact of the Program, 97% of the clients who would have remained at home would have managed using their own resources. Of those who would have moved, 37% would have moved to a Personal Care Home.

Today if service limits were established, 56% of Eastman clients could manage with their own resources (a high percentage would ask family/friends for help). Equally important is that 44% of clients either did not know what they would do or they would move into a Personal Care Home (69%).

In summary, Eastman's service provision may differ from other regions in that they are servicing a higher percentage of non-English speaking clients and clients living in elderly persons housing units. Outside household maintenance services may not be as important in Eastman as in other regions given the number of clients living in apartments.

Culturally, client needs, requests, and preferences may be diverse. They also have a high percentage of clients with family close by; although cultural beliefs may influence the degree to which family members participate in client care, even though clients reported they would ask family/friends to assist if service limits were established.

There is a question of over-servicing in the RN nursing service. Again, the validity of this statement is clouded by the fact that clients are not always the best judge of their need for professional services. Over servicing statements regarding equipment/supplies/dressing services is not possible given the small number of clients utilizing these services. Finally, Eastman clients are less capable than Westman clients of managing their care needs using their own resources. This would have implications for service limits in this region.

Central (n=62)

Central region is basically serving a client population that is:

- English (71%) and German (17%);
- female (69%), elderly (27% over 85 years) and middle-aged (23%) between 19 and 64 years);
- predominately house dwellers (69%);
- widowed (55%) or married (31%);
- not living physically close to family (43%) whose closest relatives do not live in the same city as the client; and,
- living alone (55%).

Central region clients also reported that they:

- valued all their services (21%) equally but a higher percentage reported that they valued homemaking services (24%);
- required additional homemaking services (19%) and personal care services (6%);
- did not require current RN (27%), LPN (29%) nursing services and personal care (18%) services;

- rated the Program services as excellent (35%) or good (53%);
- learned of the complaint process from individuals outside the Program (32%) although they would contact Program staff to register service complaints (94%); and,
- did not have concerns regarding the Program (92%).

As for the impact of the Program, 91% of clients remaining home would have managed their care needs. Of those who would have moved, 18% would have moved to a Personal Care Home.

Today, if service limits were established, 61% of Central clients would manage using their own resources.

In summary, Central region because of its high percentage of house dwellers and female clients may have a need for outside home maintenance service. Also since client family are not close, Central clients may rely more on Program services than other regions. These factors may account for the request for additional homemaking services from the region.

Again, there appears to be over servicing in relation to nursing services in Central region. The cautionary note that clients may not be capable of accurately assessing their needs for nursing services mentioned previously, also applies here. The potential over servicing of personal care is apparent in Central region; clients are usually capable of determining their needs for personal care.

Finally, Central clients are capable of withstanding Program service limits if established.

Interlake (n-82)

The client population is outlined below for the Interlake region. Clients are:

- predominately English (89%);
- generally female (67%) and elderly (76% are over 65);
- house dwellers (71%);
- married (40%) or widowed (40%);
- living close to family (62%); and,
- living with someone else (59%) who is not healthy (46%) but does not work outside the home (77%).

Interlake clients surveyed reported that they:

- valued homemaking (35%) and personal care services (26%);
- needed extra physiotherapy (11%) and equipment services (10%);
- did not need the personal care (14%) and RN nursing (33%) services;
- rated the Program services as excellent (49%) or good (41%);
- register a service complaint with program staff (75%); and,
- did not have concerns with the Program (93%).

As for the impact of the Program, 81% of Interlake clients remaining at home would have managed their care needs with their own resources. Of those who would have moved, 21% would have moved in with family.

Today, if service limits were established, 45% of Interlake clients would either be forced to move or are not sure of their response. Equally noteworthy is that 55% of the clients reported that they were capable of managing with their own resources.

In summary, while Interlake clients are satisfied with Program services they do see a need for additional therapy and equipment services. The rationale for these requests should be explored.

Consistent with the general pattern of potential nursing over-servicing, Interlake client responses also support this finding. The data regarding health status of persons living with the client suggest that extra supports (and possibly extra services) are needed to care for Interlake clients. Respite and Adult Day Care services may be important for these clients. Finally, Interlake clients would rely on family to provide service if Program limits were established.

Parklands (n=59)

Parklands region client population is predominately:

- . English (88%);
- . elderly (83% over 65 years) and female (69%);
- . house dwellers (68%); and,
- . widowed (57%) and living alone (66%) with family living close by (54%).

Parklands client respondents reported that they:

- . valued homemaking services (51%);
- . did not require additional services;
- . required the services they currently received;
- . rate the services as good (59%); and,
- . did not have concerns regarding the Program (97%).

As for Program impact in Parklands, a high percentage (25%) of clients remaining at home would not have replaced the service provided by the Program. Of those who would have moved, 48% would have entered a Personal Care Home. Today, if Program limits were established, a high percentage of clients (39%) are unsure of their response; however, 46% reported that they were capable of managing with their own resources.

In summary, Parklands region, relative to the other regions, delivers adequate services (type and frequency). Very few clients requested additional services or reported the unnecessary placement of c[illegible]t services. The statement of appropriate services is further supported by the lack of concerns regarding the Program. The high percentage of clients living alone and widowed points to a need for social services to deal with social isolation and grieving in this region.

At present, a high percentage of Parklands clients are not prepared for service limits. If service limits were established, preparatory work is needed in Parklands.

Norman (n=24)

The client population for the Norman region is outlined below. Clients are:

- English (96%);
- female (75%) and elderly (79% are over 65);
- living in apartments (46%) and houses (50%); and,
- widowed (58%) and living alone (58%) with family living close by (79%).

Norman clients responded during the survey that they:

- valued homemaking services (38%) and all services equally (33%);
- did not require additional services;
- did not require the homemaking (11%), RN nursing (22%) and LPN nursing (12%) services currently received;
- rated the services as excellent (62%); and,
- did not have concerns regarding the Program.

As for the impact of the Program in Norman, 83% of clients remaining at home would replace the service with another source. Of those who would have moved, 50% would have moved into a Personal Care Home. The Norman region was the only region where clients indicated that the service originally sought from the Program had to be provided. In the other regions, some clients indicated that they would not have used any help.

Today, if service limits were established, 54% of Norman clients would manage using their own resources (a high percentage indicated a willingness to pay for the service); 38% are unsure of their response to service limits.

In summary, Norman region clients support the general finding of over-servicing with regard to nursing services. They are, however, the only region to report homemaking over servicing (i.e., more than 10% of the clients receiving the service did not believe it necessary). Given their willingness to pay for services, a not-for-profit homemaking service should do well in this region.

As with Parklands region, the high percentage of widowed clients and clients living alone in Norman suggests the need for social intervention. The lack of social workers in this region is, therefore, of concern. In addition to the need for social workers, the fact that a high percentage of Norman clients are female, living alone and living in houses also suggests the need for home maintenance services in this region. Norman region is another region where clients are not prepared for service limits, although those who are, reported a willingness to pay for services.

Thompson (n=5)

The small sample size in Thompson, although proportionate, prevented a true statistical analysis of regional variations. Any generalizations regarding Thompson findings, therefore, would be inappropriate given the size of the representative sample.

There were, however, interesting descriptive statistics regarding Thompson region that are outlined below. These findings include:

- a lack of clients over 85 years;
- 60% of clients valued homemaking the most; and,
- 33% of clients reported not needing homemaking services.

Winnipeg North (n-179)

The Winnipeg North region serves a client population that:

- is English (77%) and Ukrainian (11%);
- is elderly (85%) and female (73%);
- is living in houses (55%);
- is widowed (50%) or married (40%); and,
- has family living in Winnipeg (87%) but is living alone (54%).

Winnipeg North clients reported that they:

- valued homemaking services the most (56%);
- needed additional homemaking (20%) and physiotherapy (10%) services;
- did not need RN nursing (18%) services;
- rated Program services as good (49%); and,
- had concerns regarding the Program (12%).

As for Program impact, 85% of Winnipeg North clients remaining at home would have managed to meet their care needs with their own resources. In fact, 23% would not have replaced the service with family/friends or with a paid service. Of those who would have moved, 56% would have moved into a Personal Care Home.

Today, if service limits were established, 44% of clients would manage with their own resources, although 22% reported that they would have to move (60% into a Personal Care Home) and a further 34% are unsure of their response to service limits.

In summary, Winnipeg North clients also support the general finding of nursing over-servicing, valued homemaking services, and the need for some additional services. Generally, Winnipeg North clients had a higher percentage of clients than other regions requesting additional Program services. The rationale for additional services should be explored further.

The high percentage of family living close to clients begs the question of how they are currently involved in the care plan, and whether or not they could be further involved (reducing the need for program services). Finally, as with several other regions, Winnipeg North clients are not prepared for service limits. Despite the unprepared percentage, it was interesting to note that 19% of clients could manage with less service.

Winnipeg South (n=165)

Winnipeg South client population highlights are outlined below. These include:

- . English speaking clients (89%);
- . elderly (89%) and female clients (72%);
- . apartment dwellers (60%); and,
- . widowed clients (54%) living alone (59%) with family close by (87%).

Winnipeg South survey respondents reported that they:

- . valued homemaking services (56%);
- . did not need personal care (14%), orderly (18%), RN nursing (12%), LPN nursing (12%), adult day care (12%), respite care (20%) or equipment (18%) services;
- . rated Program services as good (52%); and,
- . had concerns regarding the Program (10%).

As for Program impact on Winnipeg South clients, 87% of clients remaining at home reported an ability to manage using their own resources. Of those who would have had to move, 45% would have moved to a Personal Care Home.

Today, if service limits were established, 35% of Winnipeg South clients are unprepared, and 46% indicated an ability to manage with their own resources. Of those clients who indicated they would move if service limits were established, 66% would move to a Personal Care Ho[illegible]

In summary, Winnipeg South clients clearly receive more services than they believe are necessary. This over servicing should be investigated. While it has been mentioned that clients are not always capable of determining their needs, the lengthy list of different services not needed by clients suggests a general trend of over-servicing in Winnipeg South.

As with Winnipeg North, the close proximity of family to clients in Winnipeg South indicates that family are available to assist with client care. This assumption, however, requires validation. Finally, Winnipeg South clients also report an uncertainty of response to service limits.

Winnipeg West Central (n=141)

Winnipeg West Central clients are similar to Winnipeg North and South clients with a few exceptions. These exceptions include a higher percentage of clients who:

- are English (93%);
- are male (31%);
- are single (17%);
- live alone (69%); and,
- live with unhealthy individuals (66%).

The Winnipeg West Central clients surveyed reported that they:

- valued all services equally (25%) and homemaking services (46%);
- needed additional homemaking services (24%);
- did not need the current equipment services (15%); and,
- rated the Program services as good (51%).

As for Program impact on Winnipeg West Central clients, 88% of the clients who would have remained at home would have managed their care needs using their own resources. Of those who would have moved, 59% would have moved into a Personal Care Home.

Winnipeg West Central clients are not prepared for service limits. That is, 33% are unsure of their response and 20% would move if Program service limits are established. Of those who would move, 68% stated that they would move into a Personal Care Home.

In summary, Winnipeg West Central region is similar to other regions in that the pattern of valued homemaking services persists. Winnipeg West Central is dissimilar to the other regions in that the trend for nursing over servicing is not noted. Clients did, however, report a need for more homemaking services. This is not surprising given the value placed on homemaking services across the province and the high percentage of clients living alone.

The client profile in Winnipeg West Central, being somewhat different from the other Winnipeg regions, may require different levels of servicing (e.g., friendly visitor for clients living alone, male personal care attendants for the male clients, respite care for clients caring for family members, and so on).

Not unlike the other two Winnipeg regions, Winnipeg West Central clients are uncertain of their response to service limits.

General Discussion

General trends and patterns were noted amongst the regions. Compared to their counterparts in Winnipeg, rural clients are more likely to:

- . be younger;
- . be living in a house;
- . have family living outside their city;
- . be living alone;
- . value personal care services;
- . receive nursing services they do not believe necessary;
- . rate Program services as excellent;
- . contact a nurse coordinator to register a complaint;

- have utilized family/friends to provide service if the Program was not available at time of first contact;
- have moved in with family/friends if the Program was not available at first contact;
- manage if program service limits are established; and,
- move into a Personal Care Home if Program service limits forced a move.

Winnipeg clients are more likely to:

- be over 65 years;
- be living in an apartment;
- have family living close by;
- value homemaking services;
- rate Program services as good;
- contact a social worker case co-ordinator to register a service complaint; and,
- express a concern regarding the Program.

Generalizations beyond the above are not possible given the interactive capabilities of the variables. Before proceeding with any new directions in service (expansions or limits), regional variations should be incorporated. Take Yardwork Service as an example. If the Program were to begin to offer this service on a pilot basis, the high percentage of elderly female clients, clients living in a house, clients widowed and clients living alone, make Norman region a logical choice. The fact that 29% of Norman region clients are willing to pay for service, enhances the feasibility of this region as a pilot site.

V.O.N./ Hospital (n=135)

The Victorian Order of Nurses, providing care to the short-term care clients of Winnipeg, is serving a client population that is predominately:

- female (59%) and English (87%);

- adult, aged 19-84 years (86%);
- house dwellers (67%);
- married (45%) or widowed (27%)
- close to family living in the city (44%) or living in their household (28%); and,
- living with family and/or relatives (69%) who are healthy (78%) and work outside of the home (54%) on the day shift (91%).

Further, the short-term care clients in Winnipeg reported that they:

- received the appropriate service (89%) to meet their care needs (94%);
- participated in the decisions regarding the type of services received (59%) and had their preferences considered (62%);
- rated their experience in obtaining service from home care as very positive (49%) or positive (39%);
- were not aware of how to appeal a service decision (61%);
- valued nursing service the most (42%);
- did not need the homemaking (36%), RN nursing (61%), equipment (30%), or the supplies/dressing (48%) services they currently received;
- rated the services received as excellent (53%) or good (36%); and,
- did not have any concerns regarding the program (91%).

As for the impact of the program, 59% of the short-term care clients in Winnipeg would have remained at home, using help from family/relatives (52%) if the Program had not been available when they first contacted the Program.

Today, if service limits were established, 24% of Winnipeg short-term care clients would manage with less service and 27% would have family/relatives help with care. Thirty-two percent were unsure of their response to service limits.

In summary, the short-term care clients of Winnipeg, while generally quite content with service delivery, responded with answers that indicate potential over servicing in four areas: homemaking, nursing, equipment and supplies. This client perception of over servicing should be pursued further.

Some of the short-term care clients, like their long-term counterparts in Winnipeg, seem to be capable of withstanding program service limits. Others indicated that they were unprepared.

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REGIONAL DISTRIBUTION OF AGE GROUPS*
n = 1001

REGION

Age	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
0 - 18	4%	1%	5%	5%	-	4%	-	-	-	1%	10%
19 - 64	10%	20%	23%	19%	17%	17%	60%	15%	11%	13%	36%
65 - 84	62%	57%	45%	61%	59%	62%	40%	65%	65%	62%	50%
85+	24%	22%	27%	15%	24%	17%	-	20%	24%	24%	4%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	59	24	5	179	165	141	135

REGIONAL DISTRIBUTION OF SEX*
n = 1001

REGION

Sex	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Male	35%	33%	31%	33%	31%	25%	20%	27%	28%	31%	41%
Female	65%	67%	69%	67%	69%	75%	80%	73%	72%	69%	59%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	59	24	5	179	165	141	135

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF PRIMARY LANGUAGE*

n = 1001

REGION

Primary Language	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
English	93%	57%	71%	89%	88%	96%	100%	77%	89%	93%	87%
French	-	14%	8%	3%	-	-	-	7%	7%	-	2%
German	-	20%	18%	1%	2%	-	-	4%	1%	4%	2%
Ukranian	6%	4%	-	6%	10%	4%	-	11%	1%	1%	5%
Cree	1%	-	-	-	-	-	-	-	-	-	1%
Polish	-	-	-	-	-	-	-	3%	-	1%	-
Greek	-	-	-	-	-	-	-	-	1%	-	-
Other	-	5%	2%	1%	-	-	-	4%	1%	1%	3%
Not Stated	-	-	1%	-	-	-	-	-	-	-	-
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	59	24	5	179	165	141	135

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION BY TYPE OF DWELLING*

n = 1001

REGION

Type of Dwelling	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
House	66%	59%	69%	71%	68%	50%	100%	55%	37%	35%	67%
Apartment	6%	1%	10%	1%	9%	17%	-	24%	37%	33%	28%
Elderly Persons' Home	28%	36%	19%	22%	20%	29%	-	18%	23%	31%	5%
Personal Care Home	-	1%	2%	2%	-	-	-	3%	1%	1%	-
Mobile Home	-	3%	-	4%	3%	4%	-	-	1%	-	-
Other	-	-	-	-	-	-	-	-	1%	-	-
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	59	24	5	179	165	141	135

REGIONAL DISTRIBUTION OF MARITAL STATUS*

n = 1001

REGION

Marital Status	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Single	17%	7%	10%	15%	7%	-	-	3%	13%	17%	23%
Married	40%	44%	31%	40%	34%	34%	60%	40%	28%	23%	45%
Divorced/ Separated	1%	7%	3%	5%	2%	-	20%	5%	5%	10%	4%
Widowed	42%	42%	55%	40%	57%	58%	20%	50%	54%	49%	27%
Other	-	-	-	-	-	-	-	1%	-	-	-
Not Stated	-	-	1%	-	-	8%	-	1%	-	1%	1%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	59	24	5	179	165	141	135

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF LOCATION OF CLOSEST ADULT RELATIVE*

n = 1001

REGION

Location	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
In Household	10%	14%	18%	20%	3%	4%	40%	14%	14%	10%	28%
In Building	-	2%	-	1%	-	-	-	1%	5%	1%	1%
Within 3 Blocks	10%	10%	7%	12%	17%	13%	40%	8%	5%	10%	8%
In the Same City	19%	43%	27%	29%	34%	62%	-	84%	63%	65%	44%
Not in Same City	49%	20%	43%	29%	39%	4%	-	5%	5%	2%	7%
Outside Manitoba	8%	-	3%	8%	2%	17%	20%	3%	6%	10%	6%
In Another Country	3%	1%	-	1%	3%	-	-	3%	1%	-	4%
Have No Relative	-	-	2%	-	2%	-	-	2%	1%	1%	1%
Other	1%	-	-	-	-	-	-	-	-	-	-
Don't Know	-	-	-	-	-	-	-	-	-	1%	-
Not Stated	-	-	-	-	-	-	-	-	-	-	1%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	59	24	5	179	165	141	135

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF LIVING PARTNER(S)*

n = 1001

REGION

Client Lives:	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Alone	47%	37%	55%	41%	66%	58%	40%	54%	59%	69%	28%
With Spouse	37%	39%	19%	33%	32%	33%	20%	30%	25%	20%	42%
With Relatives	14%	20%	24%	26%	2%	9%	40%	15%	14%	11%	27%
With a Friend	1%	3%	-	-	-	-	-	-	1%	-	2%
Other	1%	1%	2%	-	-	-	-	1%	-	-	-
Not Stated	-	-	-	-	-	-	-	-	1%	-	1%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	59	24	5	179	165	141	135

REGIONAL DISTRIBUTION OF HEALTH STATUS OF LIVING PARTNER(S)*

n = 484

REGION

Are They Healthy	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	67%	64%	79%	52%	45%	70%	100%	55%	53%	66%	78%
No	33%	36%	21%	46%	45%	30%	-	45%	46%	34%	20%
Not Stated	-	-	-	2%	10%	-	-	-	1%	-	2%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	42	44	28	48	20	10	3	83	66	44	96

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF CLIENTS WITH LIVING PARTNERS WHO WORK OUTSIDE THE HOME*

n = 484

REGION

Work Outside?	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	24%	41%	39%	23%	20%	20%	100%	18%	27%	23%	46%
No	76%	59%	61%	77%	80%	80%	-	82%	73%	77%	54%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	42	44	28	48	20	10	3	83	66	44	96

REGIONAL DISTRIBUTION OF TYPE OF SHIFTS WORKED (PRIMARY TYPE)*

n = 146

REGION

Shift	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Days	50%	72%	73%	64%	100%	50%	67%	80%	66%	80%	91%
Evenings	-	6%	-	9%	-	-	-	7%	6%	-	-
Nights	-	-	9%	-	-	-	-	-	6%	-	-
Split Shifts	10%	17%	-	18%	-	-	33%	7%	17%	20%	7%
Other Not Stated	20%	5%	18%	-	-	50%	-	-	-	-	2%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	10	18	11	11	4	2	3	15	18	10	44

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* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF INVOLVEMENT IN DECISIONS REGARDING TYPE OF SERVICES RECEIVED*

n = 1001

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	71%	80%	65%	66%	66%	96%	60%	75%	75%	66%	59%
No	23%	19%	29%	30%	29%	4%	40%	19%	21%	28%	40%
Don't Remember	6%	1%	6%	4%	5%	-	-	6%	4%	6%	1%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	59	24	5	179	165	141	135

REGIONAL DISTRIBUTION OF CLIENT PERCEPTION THAT OFFERED SERVICES MET CARE NEEDS*

n = 1001

REGION

Met Needs	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	92%	89%	85%	90%	88%	96%	80%	80%	83%	87%	94%
No	8%	10%	13%	7%	10%	4%	20%	17%	15%	11%	6%
Don't Remember	-	1%	2%	3%	2%	-	-	3%	2%	2%	-
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	59	24	5	179	165	141	135

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF CLIENTS STILL RECEIVING SERVICES*

n = 1001

REGION

Receiving Services	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	81%	81%	795	79%	95%	92%	80%	95%	92%	95%	46%
No	19%	19%	21%	20%	5%	8%	20%	5%	8%	5%	53%
Don't Know	-	-	-	1%	-	-	-	-	-	-	1%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	59	24	5	179	165	141	135

REGIONAL DISTRIBUTION OF CLIENTS STILL RECEIVING SERVICES WHO FEEL THAT THEIR CARE NEEDS ARE BEING MET*

n = 836

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	94%	89%	96%	94%	86%	100%	100%	76%	88%	88%	93%
No	5%	9%	4%	1%	12%	-	-	19%	9%	12%	5%
Don't Know	1%	2%	-	5%	2%	-	-	5%	3%	-	2%
TOTAL	1005	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	64	57	49	65	56	22	4	171	152	134	62

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF CLIENT OPINION ON WHETHER OR NOT SERVICES WERE TYPE REQUIRED*

n = 1001

	REGION										
Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	95%	93%	98%	88%	90%	96%	100%	90%	88%	90%	89%
No	3%	6%	2%	5%	3%	4%	-	7%	8%	4%	6%
Don't Know	2%	1%	-	7%	7%	-	-	3%	4%	6%	5%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	58	24	5	179	165	141	135

REGIONAL DISTRIBUTION OF OPINION OF CLIENTS NOT RECEIVING TYPE OF SERVICES NEEDED ON WHETHER SERVICES WERE MORE OR LESS THAN NEEDED*

n = 53

	REGION										
Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
More	100%	25%	-	25%	-	-	-	8%	15%	17%	25%
Less	-	50%	100%	25%	-	-	-	61%	85%	67%	75%
Don't Remember	-	25%	-	-	100%	-	-	31%	-	16%	-
TOTAL	100%	100%	100%	100%	100%	-	-	100%	100%	100%	100%
TOTAL N	2	4	1	4	2	-	-	13	13	6	8

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF OPINION ON WHETHER OR NOT PREFERENCES WERE CONSIDERED WHEN SERVICES WERE BEING OFFERED*

n = 1001

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	73%	77%	57%	70%	71%	87%	60%	79%	63%	65%	62%
No	18%	19%	32%	24%	14%	13%	40%	14%	27%	27%	28%
Don't Remember	9%	4%	11%	6%	15%	-	-	7%	10%	8%	10%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	59	24	5	179	165	141	135

REGIONAL DISTRIBUTION OF CLIENT RATING OF EXPERIENCE IN INITIALLY OBTAINING SERVICES*

n = 1001

REGION

Rating	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Very Positive	38%	37%	34%	35%	44%	38%	40%	36%	30%	33%	49%
Positive	49%	47%	40%	52%	32%	54%	60%	44%	51%	45%	39%
Neutral	1%	5%	11%	3%	9%	-	-	7%	6%	10%	4%
Negative	3%	2%	7%	5%	-	4%	-	4%	4%	1%	1%
Very Negative	3%	2%	2%	-	3%	-	-	2%	1%	1%	1%
Not Stated	6%	7%	6%	5%	12%	4%	-	7%	8%	10%	6%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	59	24	5	179	165	141	135

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF CLIENT KNOWLEDGE CONCERNING METHOD OF APPEALING OR COMPLAINING ABOUT A SERVICE DECISION*

n = 1001

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	29%	43%	31%	39%	39%	75%	40%	41%	51%	48%	39%
No	71%	57%	69%	61%	61%	25%	60%	59%	49%	52%	61%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	59	24	5	179	165	141	135

REGIONAL DISTRIBUTION BY METHOD OF REGISTERING COMPLAINTS (AMONG THOSE WHO KNOW HOW TO REGISTER A COMPLAINT)*

n = 426

REGION

Contact:	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Family Member	4%	10%	6%	13%	4%	5%	-	5%	5%	6%	4%
Friend	-	-	-	-	-	-	-	-	1%	-	-
Social Worker/ Co-ordinator	31%	30%	47%	31%	31%	33%	100%	53%	60%	47%	17%
Nurse Co-ordinator	35%	44%	47%	19%	26%	22%	-	18%	11%	21%	36%
Other Program Staff	22%	3%	-	25%	18%	28%	-	16%	18%	18%	10%
Physician/ Doctor	4%	-	-	3%	13%	-	-	1%	2%	4%	13%
Service Worker	-	7%	-	9%	4%	6%	-	3%	1%	4%	12%
Other	-	3%	-	-	-	6%	-	1%	1%	-	8%
Don't Know	4%	3%	-	-	4%	-	-	3%	1%	-	-
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	23	30	19	32	23	18	2	74	85	68	52

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* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION FOR INFORMATIONAL SOURCE OF COMPLAINT PROCESS (AMONG THOSE WHO KNOW HOW TO REGISTER A COMPLAINT)*

n = 426

REGION

Informed By:	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Program Staff	26%	33%	21%	25%	22%	28%	-	19%	20%	18%	33%
Program Brochures	-	3%	-	-	-	5%	-	1%	6%	3%	3%
Friend/ Family	13%	7%	5%	13%	17%	6%	-	4%	8%	2%	4%
Service Worker	9%	20%	5%	3%	9%	17%	-	7%	9%	15%	13%
Social Worker	17%	17%	11%	16%	13%	11%	-	35%	25%	32%	14%
Other	22%	7%	32%	6%	22%	11%	-	19%	17%	22%	27%
Not Stated	13%	13%	26%	37%	17%	22%	100%	15%	8%	6%	
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	23	30	19	32	23	18	2	74	85	68	52

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF MOST VALUED SERVICE*

n = 1001

	REGION										
Service	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Home-making	43%	41%	24%	35%	51%	38%	60%	56%	57%	46%	12%
Personal Care Attendant	15%	26%	18%	26%	17%	4%	20%	5%	8%	-	1%
Personal Care Orderly	-	-	-	-	2%	-	-	6%	4%	7%	1%
RN/VON	4%	13%	6%	14%	5%	4%	20%	9%	4%	13%	42%
LPN	-	1%	6%	-	5%	8%	-	2%	2%	3%	-
Physio-therapy	1%	1%	2%	1%	-	-	-	-	1%	-	-
Occupational Therapy	4%	-	2%	1%	2%	-	-	2%	-	-	-
Adult Day Care	4%	-	3%	-	-	-	-	3%	3%	-	-
Respite Care	-	-	3%	-	2%	-	-	1%	1%	-	-
Equipment	1%	3%	5%	1%	2%	4%	-	1%	1%	-	11%
Supplies/ Dressings	6%	4%	3%	-	-	-	-	-	-	1%	3%
Meals on Wheels	-	-	5%	-	-	8%	-	1%	1%	1%	-
Community Therapists	1%	-	-	-	-	-	-	-	1%	-	-
All Equal	18%	7%	21%	18%	13%	33%	-	11%	13%	25%	28%
Other	3%	2%	-	3%	-	-	-	1%	1%	1%	-
Not Stated	-	2%	2%	1%	1%	-	-	2%	3%	3%	2%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	59	24	5	179	165	141	135

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR EXTRA HOMEMAKING SERVICES*

n = 356

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	10%	11%	19%	12%	7%	-	-	20%	17%	24%	4%
No	88%	86%	78%	88%	86%	100%	100%	73%	81%	72%	90%
Not Stated	2%	3%	3%	-	7%	-	-	7%	2%	4%	6%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	40	35	37	42	14	6	2	40	36	25	79

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR EXTRA PERSONAL CARE (ATTENDANT) SERVICES*

n = 826

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	5%	2%	6%	-	2%	-	-	7%	1%	2%	1%
No	91%	98%	88%	98%	96%	100%	100%	84%	94%	97%	95%
Not Stated	4%	-	6%	2%	2%	-	-	9%	5%	1%	4%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	57	46	34	47	45	17	4	167	143	132	134

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR EXTRA PERSONAL CARE (ORDERLY) SERVICES*

n = 934

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	3%	2%	2%	2%	2%	-	-	5%	1%	-	1%
No	95%	97%	92%	96%	97%	100%	100%	85%	93%	98%	94%
Not Stated	2%	1%	6%	2%	1%	-	-	10%	6%	2%	5%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	78	70	62	82	57	24	5	158	143	121	133

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR EXTRA NURSING (RN) SERVICES*

n = 663

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	-	2%	-	5%	2%	-	-	8%	4%	2%	-
No	99%	96%	90%	91%	92%	100%	100%	86%	91%	97%	100%
Not Stated	1%	2%	10%	4%	6%	-	-	6%	5%	1%	-
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	65	56	51	64	50	15	3	124	132	93	10

* These figures may differ from actual figures due to rounding erros.

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR EXTRA NURSING (LPN) SERVICES*

n = 914

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	-	2%	-	2%	-	-	-	4%	-	1%	1%
No	99%	97%	93%	93%	98%	100%	100%	85%	95%	97%	95%
Not Stated	1%	1%	7%	5%	2%	-	-	11%	5%	2%	4%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	77	68	55	80	50	16	5	157	149	123	134

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR EXTRA PHYSIOTHERAPY SERVICES*

n = 978

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	5%	7%	9%	11%	4%	4%	-	10%	2%	4%	6%
No	94%	90%	88%	83%	93%	96%	100%	82%	93%	93%	89%
Not Stated	1%	3%	3%	6%	3%	-	-	8%	5%	3%	5%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	77	69	60	81	59	23	5	176	160	138	130

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR EXTRA OCCUPATIONAL THERAPY SERVICES*

n = 980

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	4%	3%	2%	5%	2%	-	-	2%	4%	2%	-
No	96%	96%	92%	89%	97%	100%	100%	87%	91%	94%	95%
Not Stated	-	1%	6%	6%	1%	-	-	11%	5%	4%	5%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	74	69	60	79	58	24	5	176	162	141	132

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR EXTRA ADULT DAY CARE SERVICES*

n = 947

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	6%	1%	5%	1%	-	-	-	4%	4%	4%	1%
No	93%	96%	90%	93%	97%	100%	100%	90%	93%	93%	95%
Not Stated	1%	3%	5%	6%	3%	-	-	6%	3%	3%	4%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	76	68	58	81	58	24	5	162	148	133	134

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR EXTRA RESPITE CARE SERVICES*

n = 971

REGION

	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Response											
Yes	3%	5%	2%	1%	-	-	-	4%	3%	3%	-
No	93%	91%	92%	90%	97%	100%	100%	90%	95%	94%	95%
Not Stated	4%	4%	6%	9%	3%	-	-	6%	2%	3%	5%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	76	69	59	80	57	23	5	177	155	140	130

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR EXTRA EQUIPMENT SERVICES*

n = 877

REGION

	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Response											
Yes	5%	5%	6%	10%	4%	-	-	4%	2%	4%	2%
No	94%	92%	90%	85%	93%	100%	100%	89%	95%	95%	93%
Not Stated	1%	3%	4%	5%	3%	-	-	7%	3%	1%	5%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	72	65	51	74	55	22	5	170	154	128	81

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR EXTRA SUPPLIES/DRESSINGS SERVICES*

n = 938

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	-	2%	-	4%	5%	-	-	2%	1%	3%	2%
No	99%	94%	97%	93%	91%	100%	100%	91%	96%	96%	92%
Not Stated	1%	4%	3%	3%	4%	-	-	7%	3%	1%	6%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	71	65	59	80	57	24	5	174	161	138	104

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR EXTRA MEALS ON WHEELS SERVICES*

n = 963

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	4%	1%	6%	4%	5%	-	-	7%	3%	4%	2%
No	95%	96%	91%	94%	93%	100%	100%	87%	95%	95%	92%
Not Stated	1%	3%	3%	2%	2%	-	-	6%	2%	1%	6%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	78	67	55	82	57	20	5	176	154	134	135

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR EXTRA COMMUNITY THERAPIST SERVICES*

n = 985

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	1%	-	-	4%	3%	-	-	3%	2%	1%	1%
No	96%	97%	94%	90%	92%	100%	100%	89%	94%	96%	94%
Not Stated	3%	3%	6%	6%	5%	-	-	8%	4%	3%	5%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	77	70	62	80	59	24	5	179	162	137	130

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR CURRENTLY RECEIVED HOMEMAKING SERVICES*
n = 645

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	92%	91%	92%	98%	100%	89%	67%	97%	95%	96%	64%
No	5%	6%	8%	2%	-	11%	33%	2%	3%	4%	36%
Not Stated	3%	3%	-	-	-	-	-	1%	2%	-	-
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	39	35	25	40	45	18	3	139	129	116	56

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR CURRENTLY RECEIVED PERSONAL CARE (ATTENDANT) SERVICES*
n = 175

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	86%	88%	79%	86%	93%	100%	100%	92%	82%	78%	100%
No	14%	12%	18%	14%	7%	-	-	8%	14%	-	-
Not Stated	-	-	3%	-	-	-	-	-	4%	22%	-
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	22	24	28	35	14	7	1	12	22	9	1

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR CURRENTLY RECEIVED PERSONAL CARE (ORDERLY) SERVICES*
n = 67

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	100%	-	-	-	100%	-	-	95%	82%	95%	100%
No	-	-	-	-	-	-	-	5%	18%	-	-
Not Stated	-	-	-	-	-	-	-	-	-	5%	-
TOTAL	100%	-	-	-	100%	-	-	100%	100%	100%	100%
TOTAL N	1	-	-	-	2	-	-	20	22	20	2

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR CURRENTLY RECEIVED NURSING (RN) SERVICES*

n = 338

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	71%	79%	73%	67%	100%	78%	100%	80%	79%	90%	34%
No	29%	21%	27%	33%	-	22%	-	18%	12%	8%	61%
Not Stated	-	-	-	-	-	-	-	2%	9%	2%	5%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	14	14	11	18	9	9	2	55	33	48	125

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR CURRENTLY RECEIVED NURSING (LPN) SERVICES*

n = 87

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	50%	100%	71%	100%	100%	88%	-	96%	88%	94%	100%
No	50%	-	29%	-	-	12%	-	-	12%	-	-
Not Stated	-	-	-	-	-	-	-	4%	-	6%	-
TOTAL	100%	100%	100%	100%	100%	100%	-	100%	100%	100%	100%
TOTAL N	2	2	7	2	9	8	-	22	16	18	1

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR CURRENTLY RECEIVED PHYSIOTHERAPY SERVICES*

n = 23

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	50%	-	50%	-	-	100%	-	33%	40%	33%	40%
No	50%	100%	50%	100%	-	-	-	33%	40%	33%	40%
Not Stated	-	-	-	-	-	-	-	34%	20%	34%	20%
TOTAL	100%	100%	100%	100%	-	100%	-	100%	100%	100%	100%
TOTAL N	2	1	2	1	-	1	-	3	5	3	5

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR CURRENTLY RECEIVED OCCUPATIONAL THERAPY SERVICES*

n = 21

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	60%	100%	-	100%	100%	-	-	33%	-	-	67%
No	-	-	100%	-	-	-	-	33%	100%	-	33%
Not Stated	40%	-	-	-	-	-	-	34%	-	-	-
TOTAL	100%	100%	100%	100%	100%	-	-	100%	100%	-	100%
TOTAL N	5	1	2	3	1	-	-	3	3	-	3

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR CURRENTLY RECEIVED ADULT DAY CARE SERVICES*

n = 54

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	67%	100%	100%	-	100%	-	-	94%	77%	75%	-
No	-	-	-	100%	-	-	-	-	12%	-	100%
Not Stated	33%	-	-	-	-	-	-	6%	11%	25%	-
TOTAL	100%	100%	100%	100%	100%	-	-	100%	100%	100%	100%
TOTAL N	3	2	4	1	1	-	-	17	17	8	1

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR CURRENTLY RECEIVED RESPITE CARE SERVICES*

n = 30

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	100%	100%	67%	50%	100%	100%	-	100%	80%	100%	60%
No	-	-	33%	50%	-	-	-	-	20%	-	40%
TOTAL	100%	100%	100%	100%	100%	100%	-	100%	100%	100%	100%
TOTAL N	3	1	3	2	2	1	-	2	10	1	5

* These figure may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR CURRENTLY RECEIVED EQUIPMENT SERVICES*

n = 124

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	100%	60%	91%	100%	100%	100%	-	78%	82%	85%	69%
No	-	40%	9%	-	-	-	-	-	18%	15%	30%
Not Stated	-	-	-	-	-	-	-	22%	-	-	1%
TOTAL	100%	100%	100%	100%	100%	100%	-	100%	100%	100%	100%
TOTAL N	7	5	11	8	4	2	-	9	11	13	54

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR CURRENTLY RECEIVED SUPPLIES/DRESSINGS SERVICES*

n = 63

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	75%	80%	100%	100%	50%	-	-	100%	100%	100%	42%
No	13%	20%	-	-	50%	-	-	-	-	-	48%
Not Stated	12%	-	-	-	-	-	-	-	-	-	10%
TOTAL	100%	100%	100%	100%	100%	-	-	100%	100%	100%	100%
TOTAL N	8	5	3	2	2	-	-	5	4	3	31

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR CURRENTLY RECEIVED MEALS ON WHEELS*

n = 38

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	100%	100%	100%	-	100%	100%	-	67%	100%	100%	-
No	-	-	-	-	-	-	-	33%	-	-	-
TOTAL	100%	100%	100%	-	100%	100%	-	100%	100%	100%	-
TOTAL N	1	3	7	-	2	4	-	3	11	7	-

REGIONAL DISTRIBUTION OF PERCEIVED NEED FOR CURRENTLY RECEIVED COMMUNITY THERAPIST SERVICES*

n = 16

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	100%	-	-	50%	-	-	-	-	33%	50%	40%
No	-	-	-	-	-	-	-	-	33%	25%	20%
Not Stated	-	-	-	50%	-	-	-	-	34%	25%	40%
TOTAL	100%	-	-	100%	-	-	-	-	100%	100%	100%
TOTAL N	2	-	-	2	-	-	-	-	3	4	5

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF RATING FOR SERVICES RECEIVED*

n = 1001

REGION

	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Rating											
Excellent	48%	46%	35%	49%	37%	62%	60%	38%	37%	34%	53%
Good	47%	44%	53%	41%	59%	38%	40%	49%	52%	51%	36%
Fair	3%	10%	8%	5%	2%	-	-	8%	7%	13%	7%
Poor	-	-	2%	1%	-	-	-	2%	2%	1%	2%
Don't Know	2%	-	2%	4%	2%	-	-	3%	2%	1%	2%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	59	24	5	179	165	141	135

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF FIRST PERSON CALLED IN THE EVENT OF A PROBLEM*

n = 1001

REGION

Would Call	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Family Member	5%	1%	16%	9%	10%	4%	-	10%	9%	11%	5%
Friend	1%	1%	5%	-	-	4%	-	1%	-	1%	1%
Social Worker	18%	39%	21%	32%	29%	38%	60%	46%	50%	41%	16%
Nurse Cooordinator	25%	39%	24%	19%	24%	25%	20%	10%	10%	18%	30%
Other Program Staff	19%	7%	3%	19%	7%	29%	-	14%	14%	11%	9%
Physician	7%	7%	10%	7%	7%	-	-	2%	4%	4%	10%
Service Worker	1%	1%	-	1%	5%	-	-	2%	1%	2%	7%
Other	-			3%	-	-	20%	2%	1%	2%	4%
Don't Know	24%	5%	21%	10%	18%	-	-	13%	11%	10%	18%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	59	24	5	179	165	141	135

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF THE PRESENCE OF CONCERNS*

n = 1001

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Yes	6%	3%	8%	7%	3%	4%	20%	12%	10%	6%	9%
No	94%	97%	92%	93%	97%	96%	80%	88%	90%	94%	91%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	59	24	5	179	165	141	135

REGIONAL DISTRIBUTION OF CLIENT RESPONSE, AFTER FIRST CONTACT WITH THE C.C.P. TO POSITED UNAVAILABILITY OF THE PROGRAM*

n = 1001

REGION

Client Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Remained Home	59%	37%	37%	39%	47%	75%	60%	42%	50%	47%	59%
Moved Elsewhere	27%	54%	43%	40%	36%	17%	40%	44%	32%	37%	25%
Don't Know	14%	9%	20%	21%	17%	8%	-	14%	18%	16%	16%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	59	24	5	179	165	141	135

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* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF CLIENT RESPONSE, AFTER FIRST CONTACT WITH THE C.C.P., TO POSITED UNAVAILABILITY OF PROGRAM - AMONG CLIENTS WHO WOULD HAVE REMAINED AT HOME*

n = 479

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Would Not Have Used Any Help	15%	8%	13%	9%	25%	-	33%	23%	15%	30%	22%
Would Have Used Family/ Relatives	36%	58%	61%	47%	43%	50%	67%	45%	37%	38%	52%
Would Have Hired Own Help	38%	31%	17%	25%	25%	33%	-	17%	35%	20%	15%
Other	5%	3%	5%	3%	-	11%	-	2%	-	-	1%
Not Stated	6%	-	4%	16%	7%	6%	-	13%	13%	12%	10%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	47	26	23	32	28	18	3	75	82	66	79

REGIONAL DISTRIBUTION OF RESPONSE, AFTER FIRST CONTACT WITH THE C.C.P., TO POSITED UNAVAILABILITY OF PROGRAM - AMONG CLIENTS WHO WOULD HAVE MOVED*

n = 365

REGION

Location	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
In With Family	14%	13%	4%	21%	14%	-	50%	7%	6%	6%	9%
Into a Personal Care Home	52%	37%	44%	16%	48%	50%	50%	56%	45%	59%	21%
Into an E.P.H.	19%	24%	19%	18%	5%	25%	-	20%	21%	13%	3%
Other	5%	16%	15%	27%	19%	25%	-	6%	3%	13%	56%
Not Stated	10%	10%	18%	16%	14%	-	-	11%	25%	9%	11%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	21	38	27	33	21	4	2	79	53	53	34

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF RESPONSE, TODAY, TO POSITED INTRODUCTION OF SERVICE LIMITS FOR HOME CARE/CONTINUING CARE*

n = 1001

REGION

Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Manage With Less	23%	13%	16%	17%	10%	8%	40%	19%	19%	19%	24%
Pay to Have Help	28%	6%	13%	15%	15%	29%	20%	10%	11%	10%	13%
Ask Family/ Friend	16%	37%	32%	23%	21%	17%	20%	15%	16%	18%	27%
Move	10%	23%	8%	10%	15%	8%	-	22%	19%	20%	4%
Don't Know	23%	21%	31%	35%	39%	38%	20%	34%	35%	33%	32%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	79	70	62	82	59	24	5	179	165	141	135

* These figures may differ from actual figures due to rounding errors.

REGIONAL DISTRIBUTION OF RESPONSE, TODAY, TO THE POSITED INTRODUCTION OF SERVICE LIMITS - AMONG CLIENTS WHO WOULD HAVE MOVED*

n = 159

REGION

Location	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
In with Family/ Friends	-	6%	-	-	11%	-	-	2%	-	-	14%
Into Elderly Persons Housing Unit	-	6%	17%	25%	22%	-	-	18%	16%	10%	-
Into Personal Care Home	88%	69%	83%	50%	56%	100%	-	60%	66%	68%	57%
Other	12%	6%	-	13%	11%	-	-	10%	6%	13%	29%
Not Stated	-	13%	-	12%	-	-	-	10%	12%	9%	-
TOTAL	100%	100%	100%	100%	100%	100%	-	100%	100%	100%	100%
TOTAL N	8	16	6	8	9	2	-	40	32	31	7

* These figures may differ from actual figures due to rounding error.

APPENDIX O

CLIENT SURVEY DATA

APPENDIX O

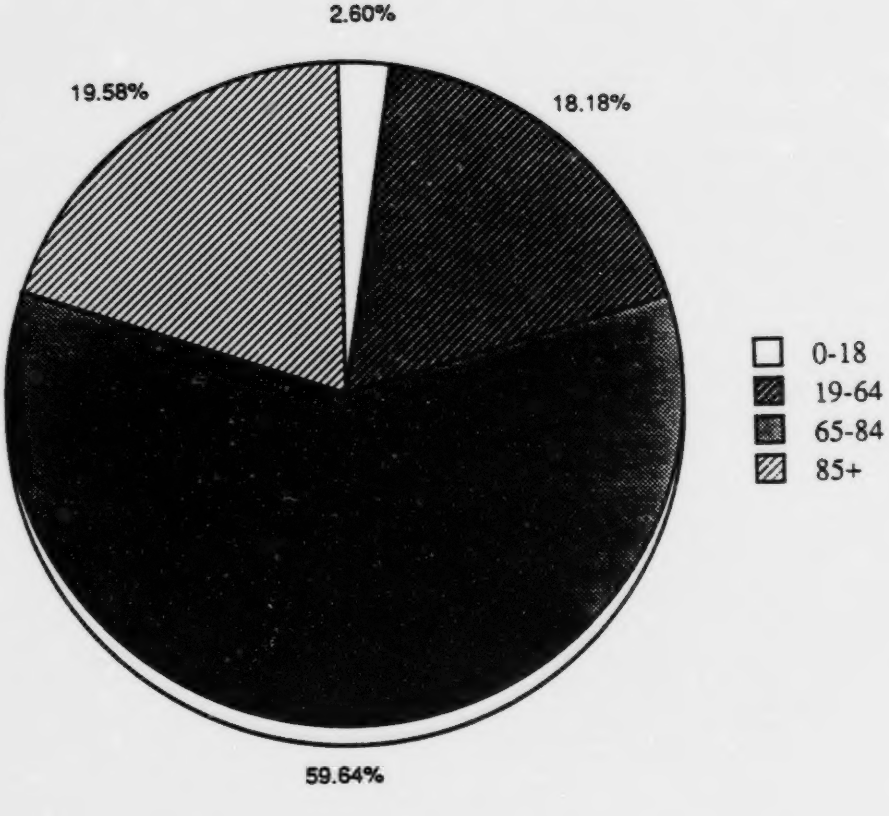
CLIENT SURVEY FIGURES

O-1 CLIENT AGE GROUPS
O-2 CLIENT GENDER
O-3 MARITAL STATUS
O-4 LANGUAGE SPOKEN
O-5 CLIENT DWELLING
O-6 CLIENT LIVING ARRANGEMENTS
O-7 HEALTH STATUS OF INDIVIDUALS LIVING WITH CLIENT
O-8 EMPLOYMENT STATUS OF INDIVIDUALS LIVING WITH CLIENT
O-9 SHIFT WORKED BY INDIVIDUAL LIVING WITH CLIENT
O-10 CLOSEST CLIENT ADULT RELATIVES
O-11 CLIENT INVOLVEMENT IN INITIAL SERVICE DECISION
O-12 INITIAL SERVICES MEETING CLIENT CARE NEEDS
O-13 CLIENTS STILL RECEIVING SERVICES
O-14 INITIAL SERVICES STILL MEETING CLIENT NEEDS
O-15 SERVICE TYPE MEETING CLIENT NEEDS
O-16 CLIENT PREFERENCE CONSIDERATION WITH SERVICE DECISION
O-17 CLIENT RATING OF EXPERIENCE INITIALLY OBTAINING SERVICES
O-18 KNOWLEDGE OF APPEAL PROCESS
O-19 CLIENT CONTACT TO REGISTER A COMPLAINT
O-20 METHOD OF LEARNING APPEAL PROCESS
O-21 CLIENT CONTACT FOR SERVICE PROBLEMS
O-22 MOST VALUED SERVICE
O-23 SECOND MOST VALUED SERVICE
O-24 THIRD MOST VALUED SERVICE
O-25 CLIENT RATING OF SERVICES
O-26 CLIENT CONCERNS REGARDING SERVICES
O-27 CLIENT RESPONSE IF PROGRAM NOT AVAILABLE
O-28 CLIENT RESPONSE IF REMAINED AT HOME AND HOME CARE NOT AVAILABLE
O-29 CLIENT LOCATION IF NO SERVICES FORCED A MOVE
O-30 CLIENT REACTION TO SERVICE LIMITS
O-31 CLIENT LOCATION IF SERVICE LIMIT FORCED A MOVE

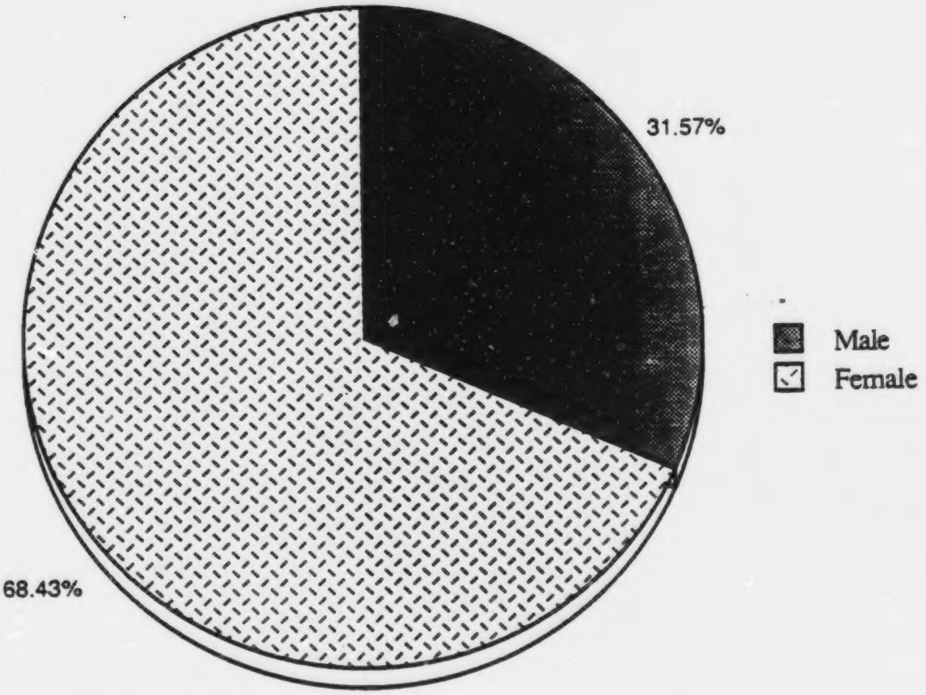
CLIENT SURVEY - TABLES

0-32 CLIENT SATISFACTION WITH FREQUENCY OF HOME CARE SERVICES
0-33 CLIENT SATISFACTION WITH FREQUENCY OF HOMEMAKING SERVICES
0-34 CLIENT SATISFACTION WITH FREQUENCY OF HOMEMAKING SERVICES (BY AGE)
0-35 CLIENT SATISFACTION WITH FREQUENCY OF COMMUNITY THERAPY SERVICES
0-36 CLIENT SATISFACTION WITH FREQUENCY OF COMMUNITY THERAPY (BY AGE)
0-37 CLIENT ASSESSMENT OF NEED FOR HOME CARE SERVICES RECEIVED
0-38 CLIENT ASSESSMENT OF THE NEED FOR RN NURSING SERVICES
0-39 CLIENT ASSESSMENT OF THE NEED FOR SUPPLIES/DRESSINGS
0-40 CLIENT ASSESSMENT OF THE NEED FOR ADDITIONAL HOME CARE SERVICES
0-41 CLIENT ASSESSMENT OF THE NEED TO IMPROVE HOME CARE SERVICES RECEIVED
0-42 CLIENT ASSESSMENT OF THE NEED TO IMPROVE HOMEMAKING SERVICES
0-43 CLIENT ASSESSMENT OF THE NEED TO IMPROVE HOMEMAKING SERVICES (BY AGE)
0-44 CLIENT ASSESSMENT OF THE NEED FOR COMMUNITY THERAPY SERVICES
0-45 REASONS WHY CLIENTS DID NOT PARTICIPATE IN INITIAL HOME CARE SERVICE DECISIONS
0-46 CLIENT REASONS WHY INITIAL SERVICES OFFERED DID NOT ADEQUATELY MEET CLIENT CARE NEEDS

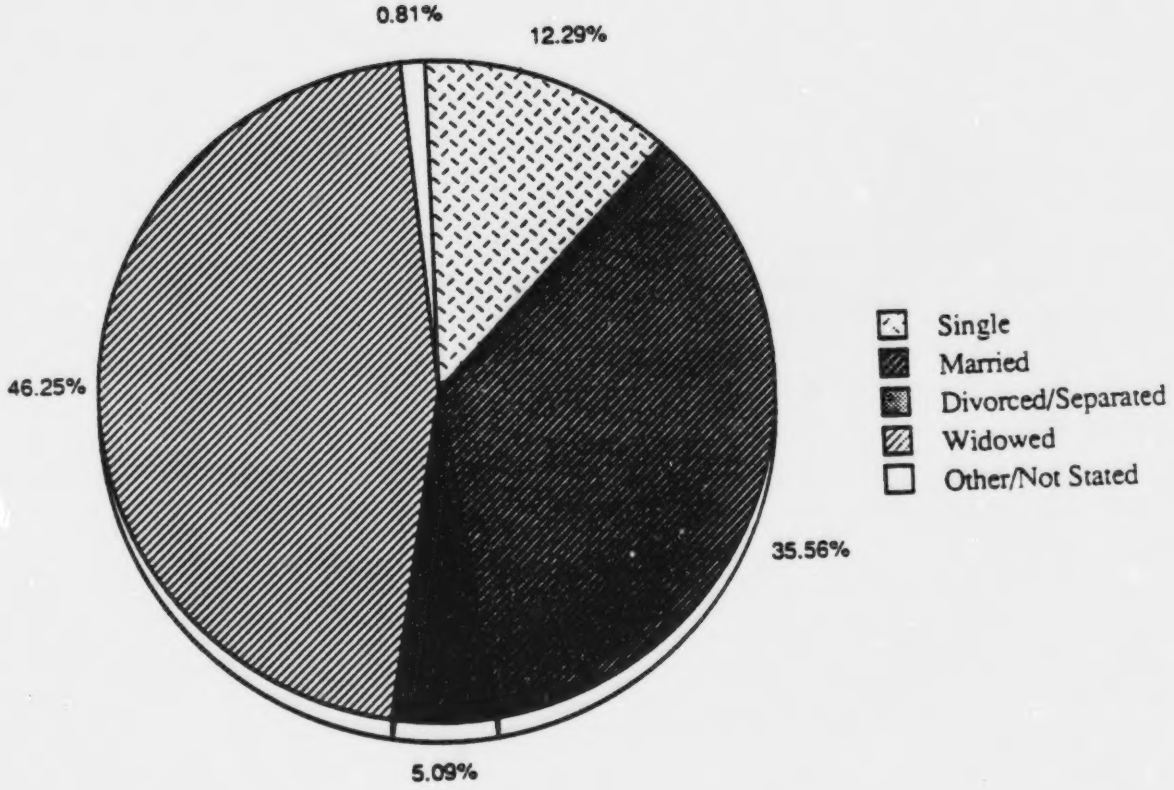
Client Age Groups
(n = 1001)



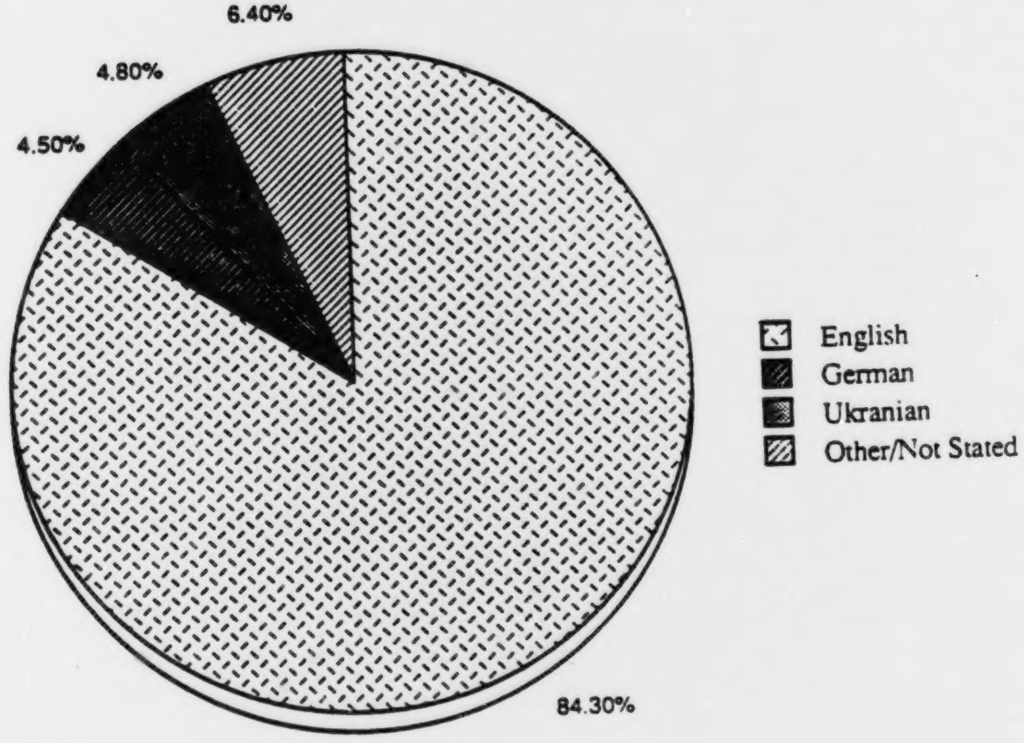
Client Gender
(n = 1001)



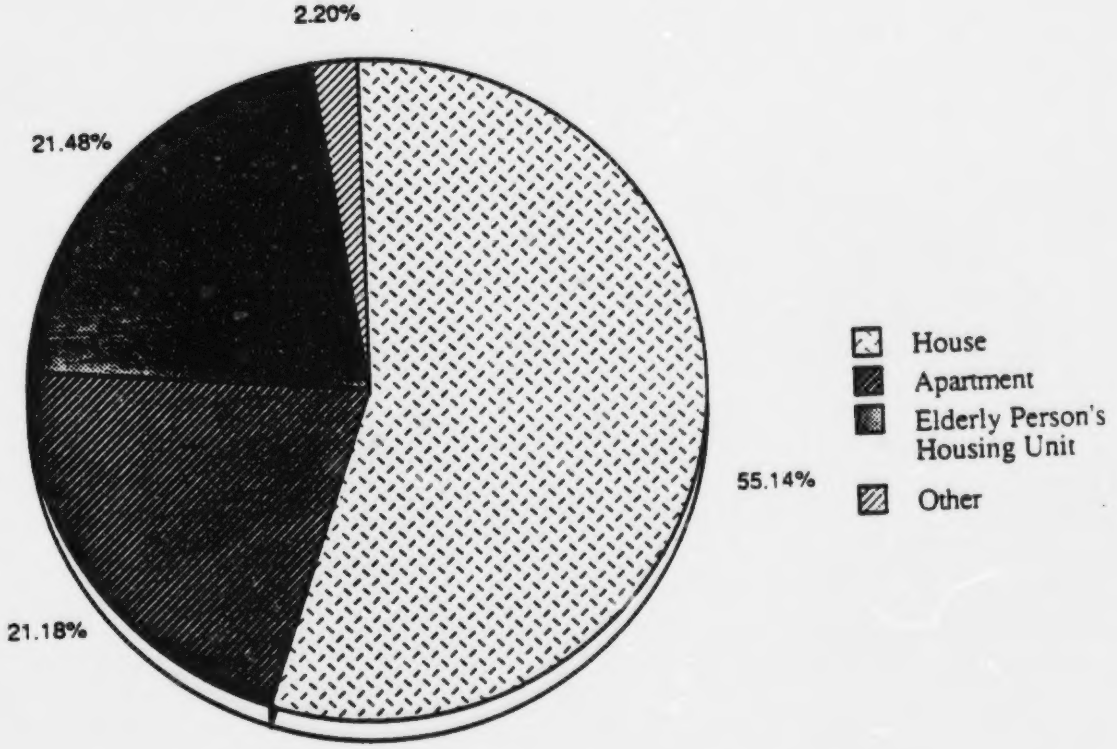
What is Your Marital Status?
(n = 1001)



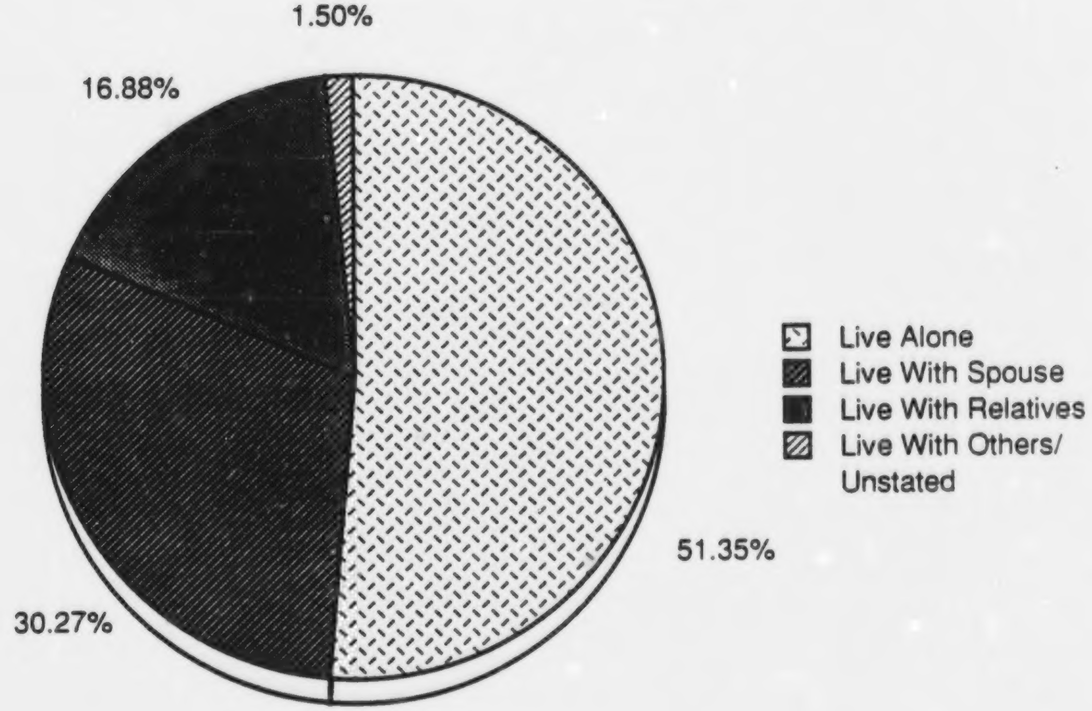
Which of the Following Languages Do You Speak Most Often?
(n = 1001)



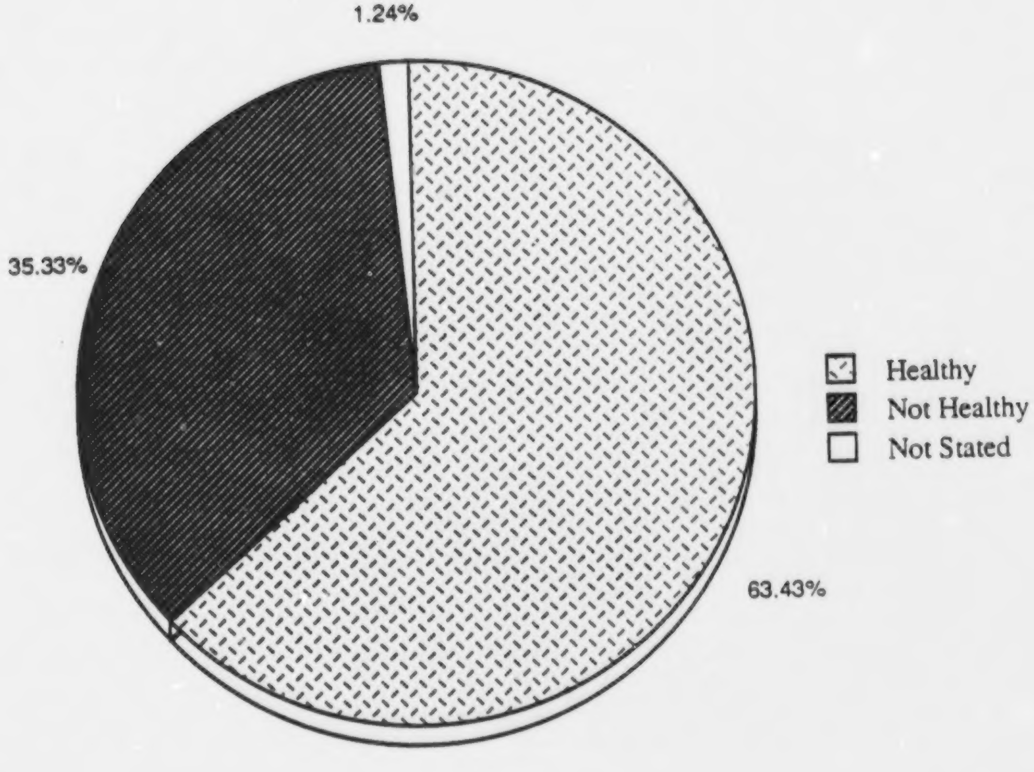
What Type of Dwelling Do You Presently Live In? (n = 1001)



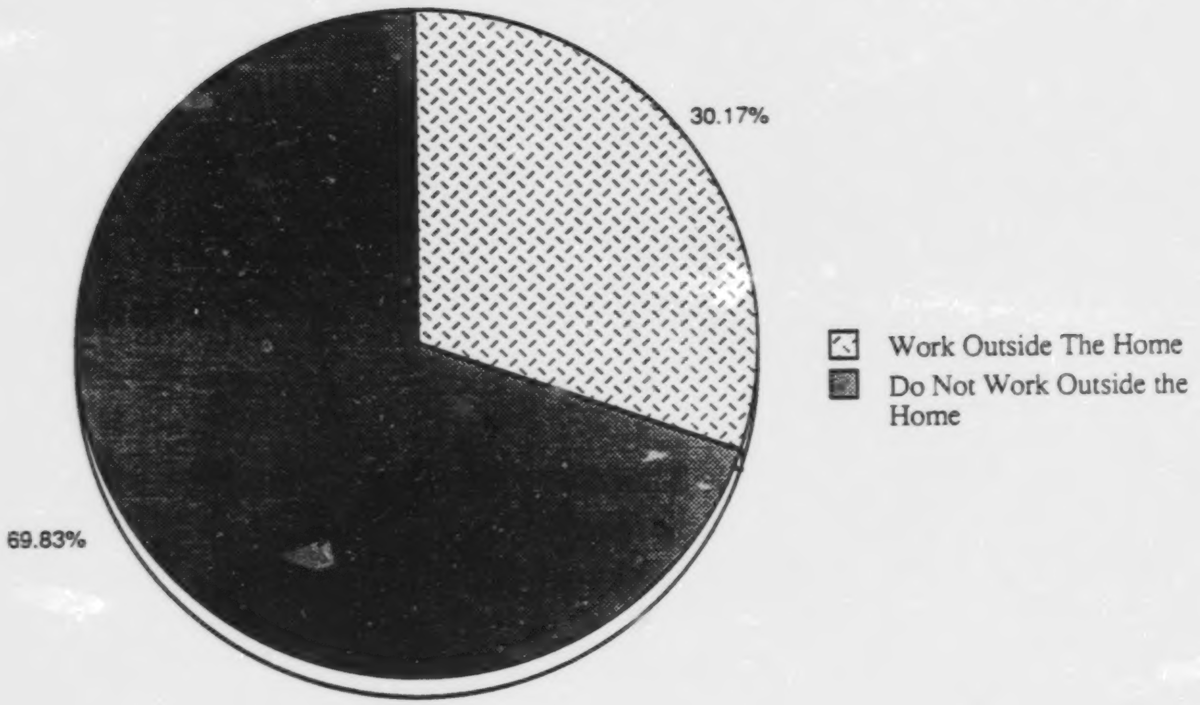
At Present, Who Do You Live With?
(n = 1001)



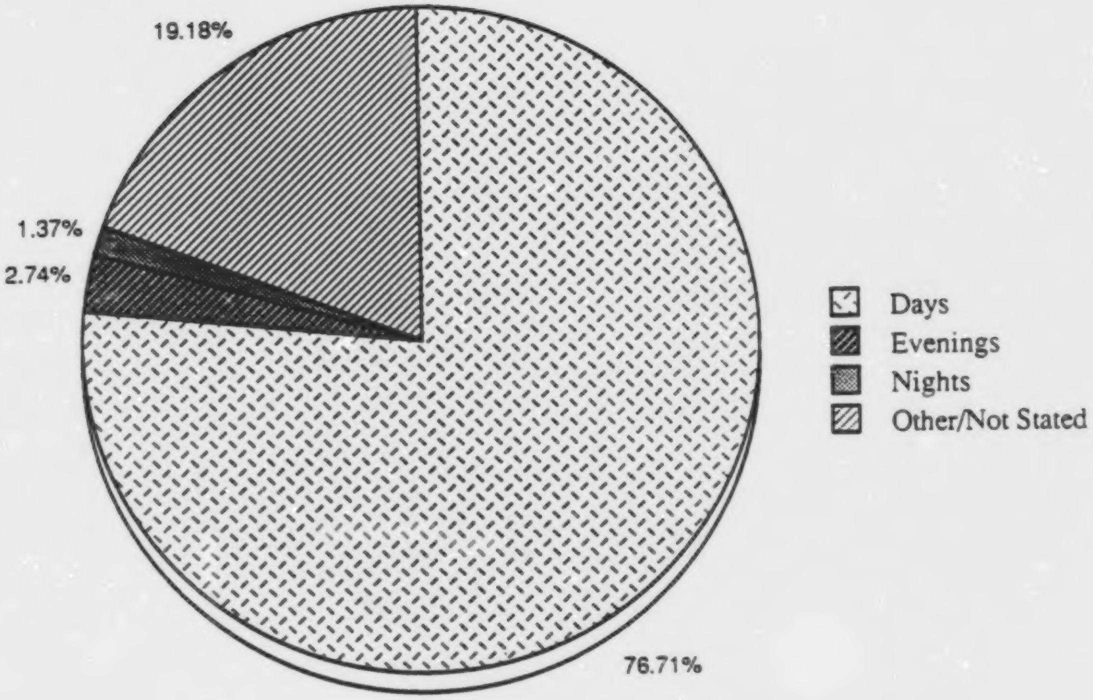
Are the Individuals Living With You Healthy?
(n = 484)



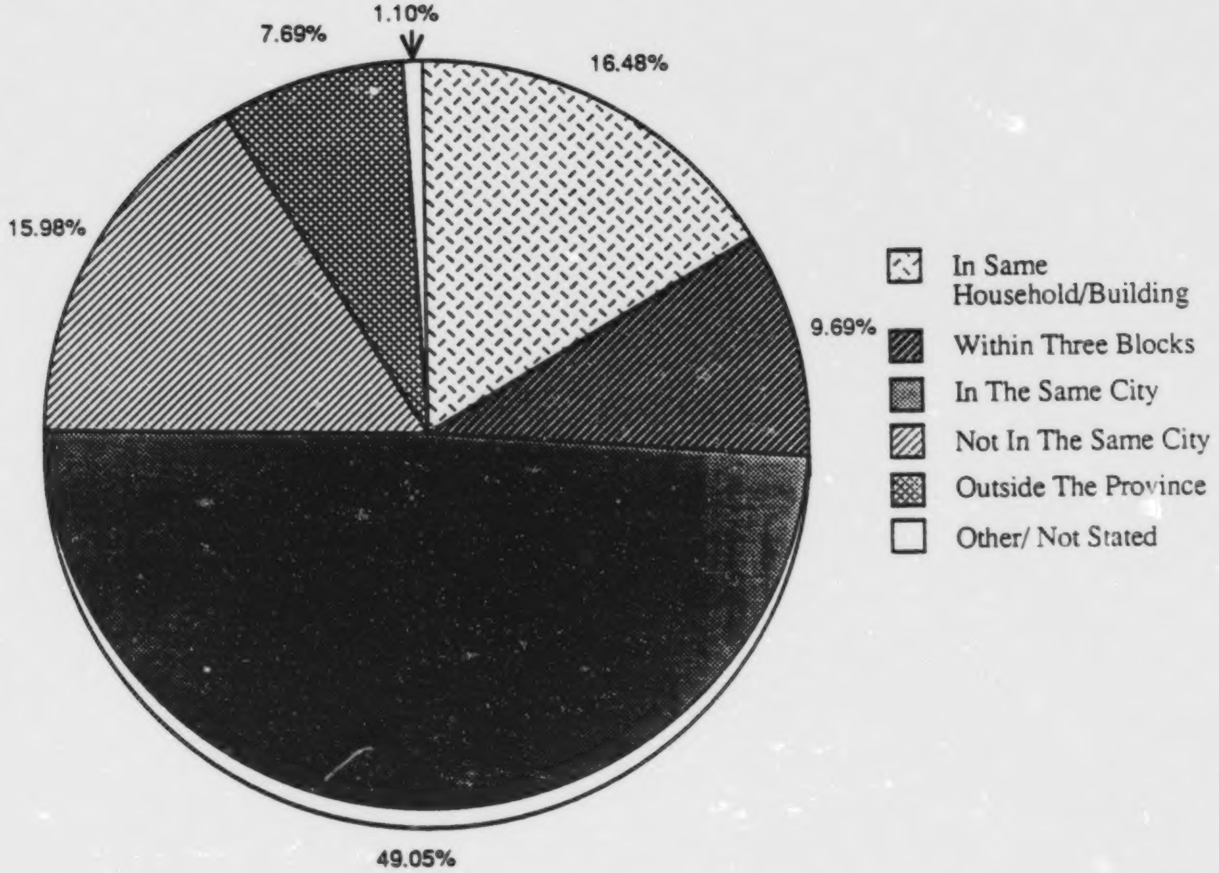
Do the Individuals Living With You Work Outside the Home?
(n = 484)



What Shifts Do the Individuals Living With You Work?
(n = 146)

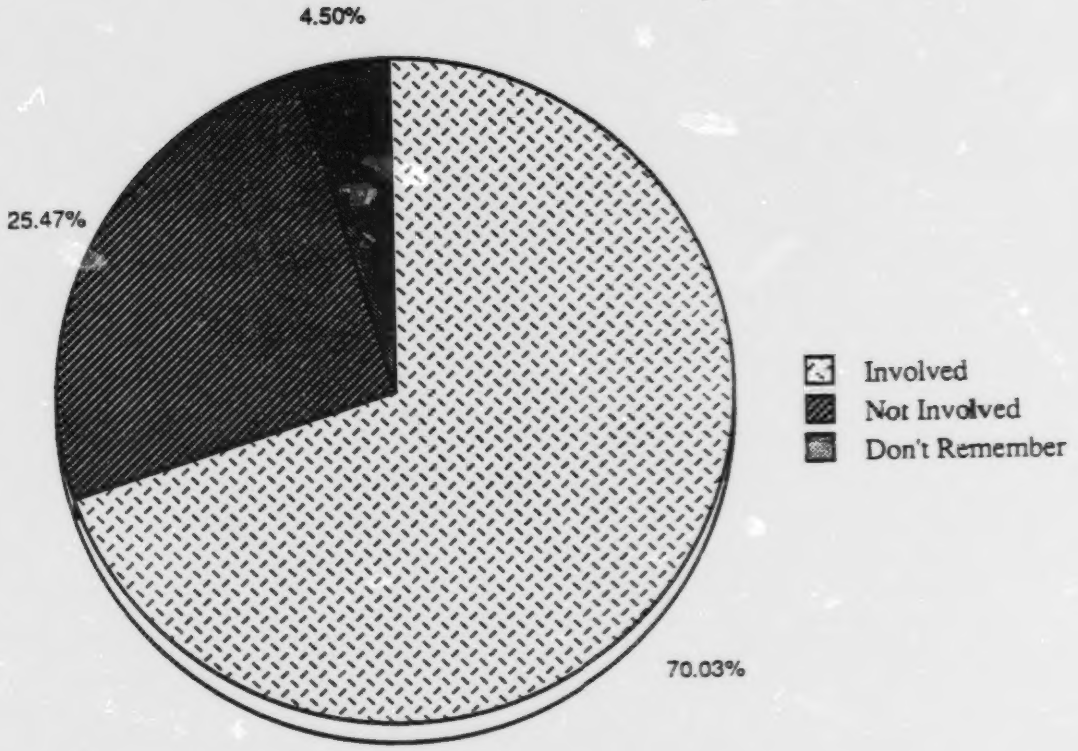


Where Are Your Closest Adult Relatives (Excluding Spouse) Located? (n = 1001)

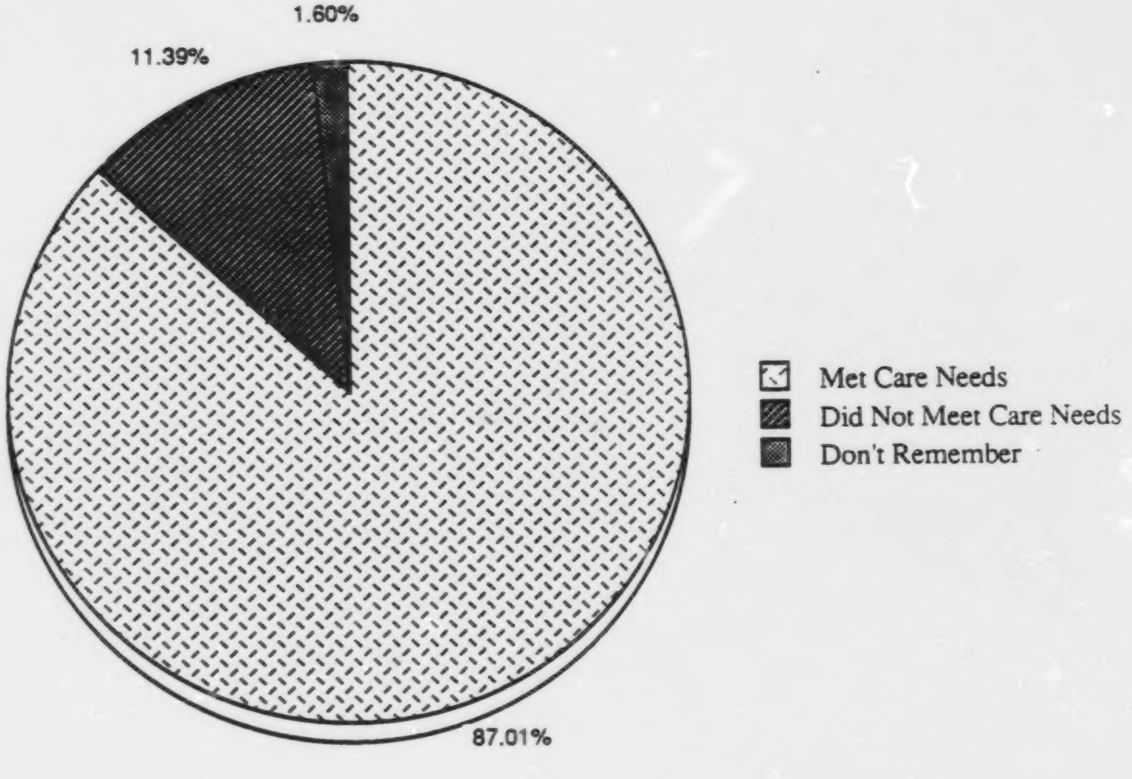


Were You or Your Family Involved in the Decisions Regarding the Type of Services You Would Receive to Meet Your Needs?

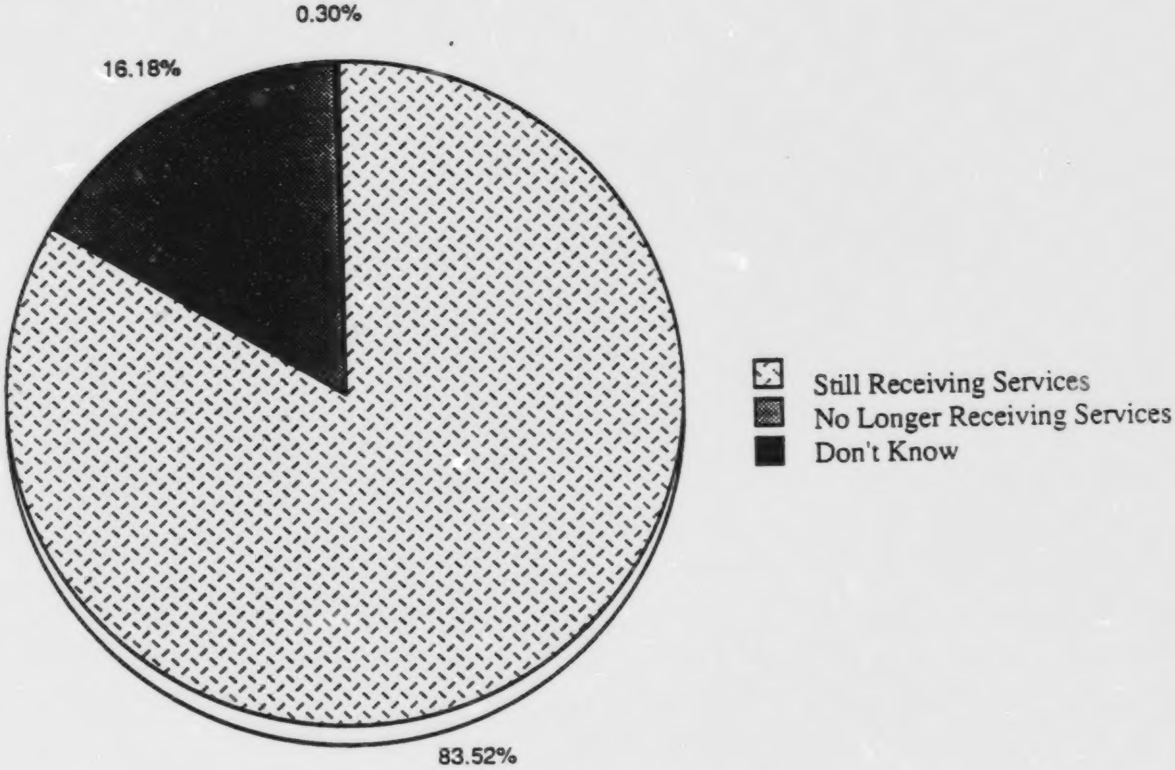
(n = 1001)



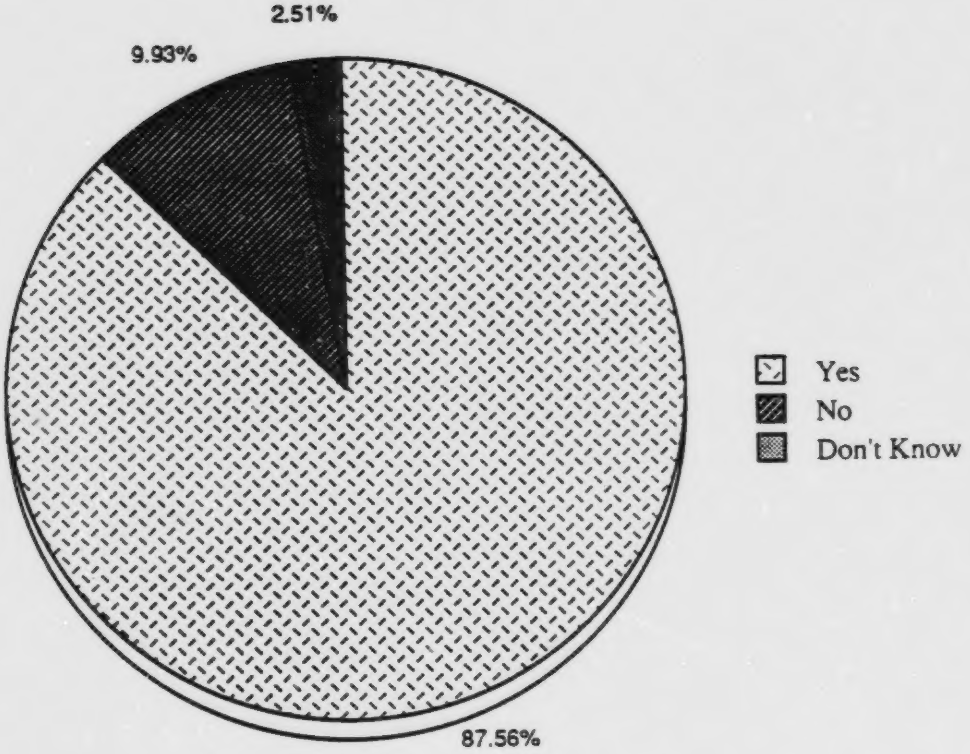
Do You Feel that the Services You were Offered Adequately Met Your Care Needs? (n = 1001)



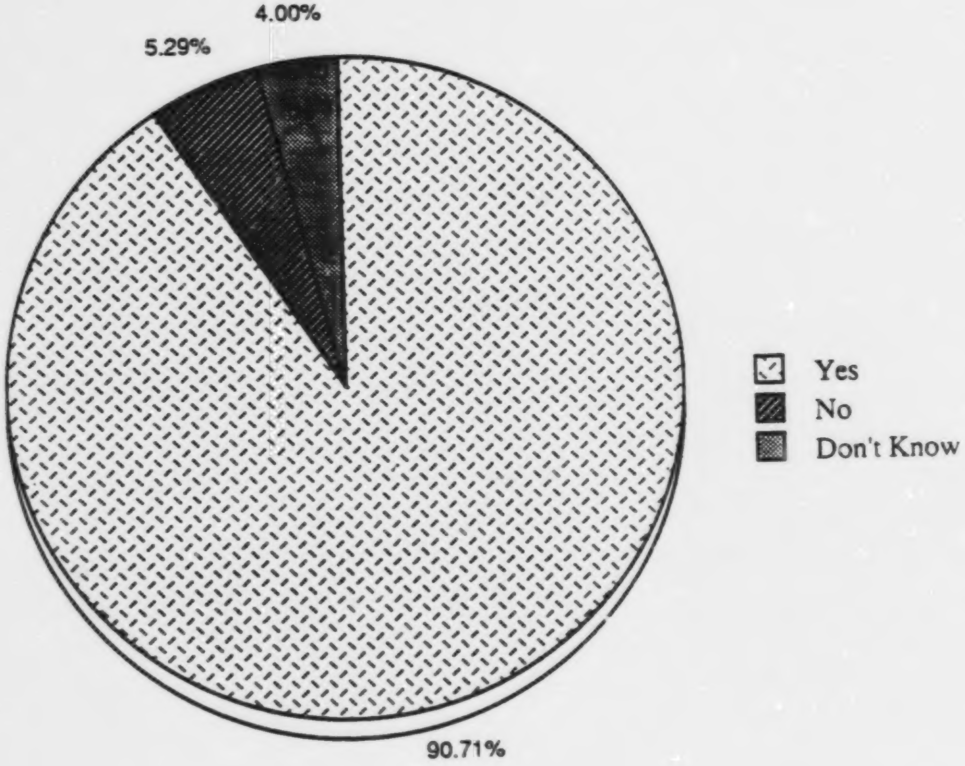
Are You Still Receiving Services?
(n = 1001)



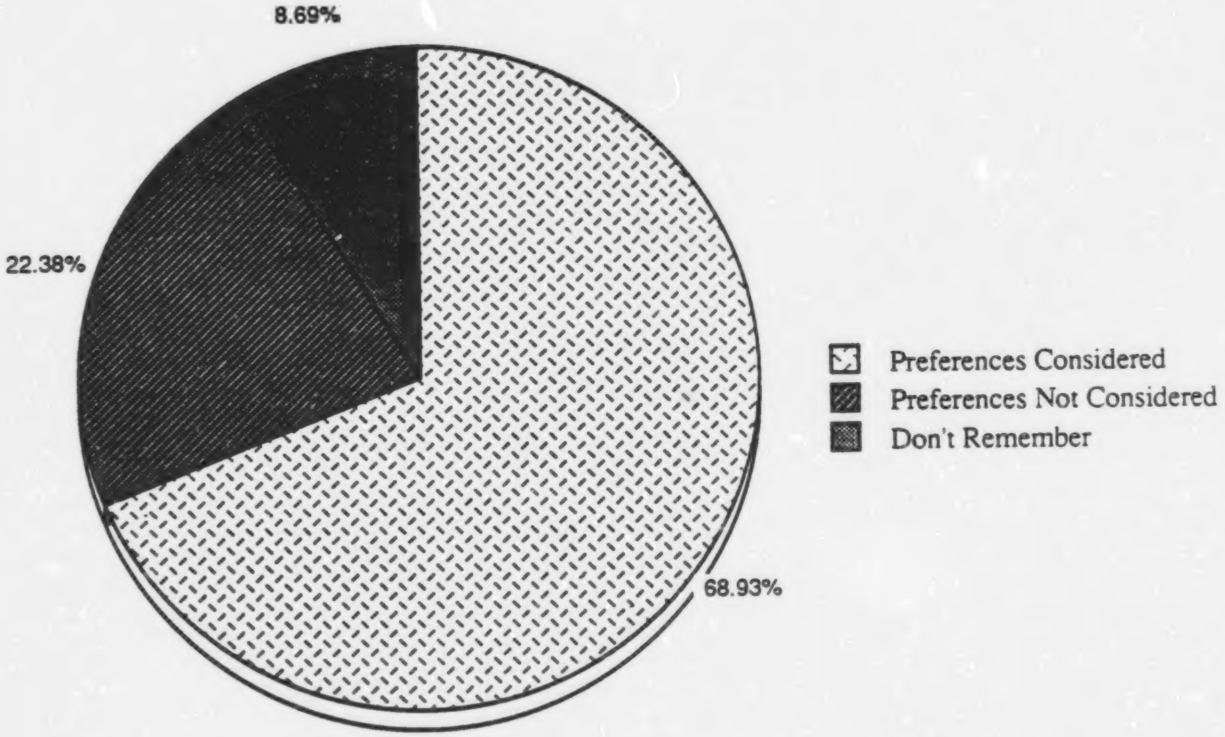
(If Still Receiving Services) Do the Services Still Meet Your Care Needs?
(n = 836)



Were the TYPE of Services That were Put into Place by the Program Staff What You Thought You Needed? (n = 1001)

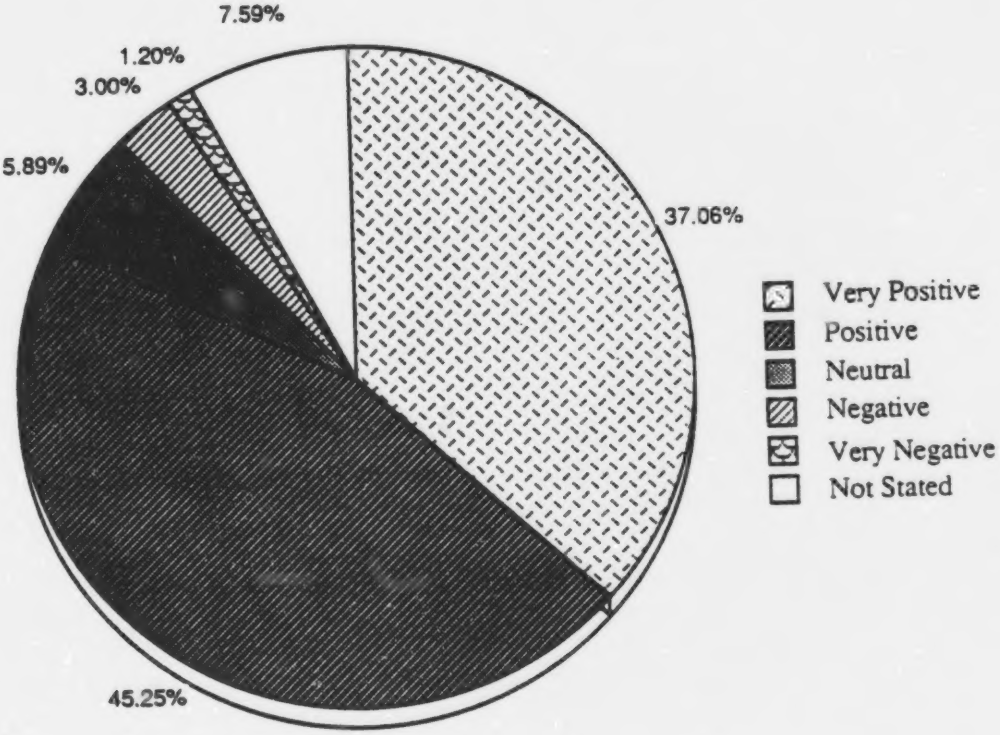


Were Your Preferences Considered When the Services Were Being Ordered?
(n = 1001)



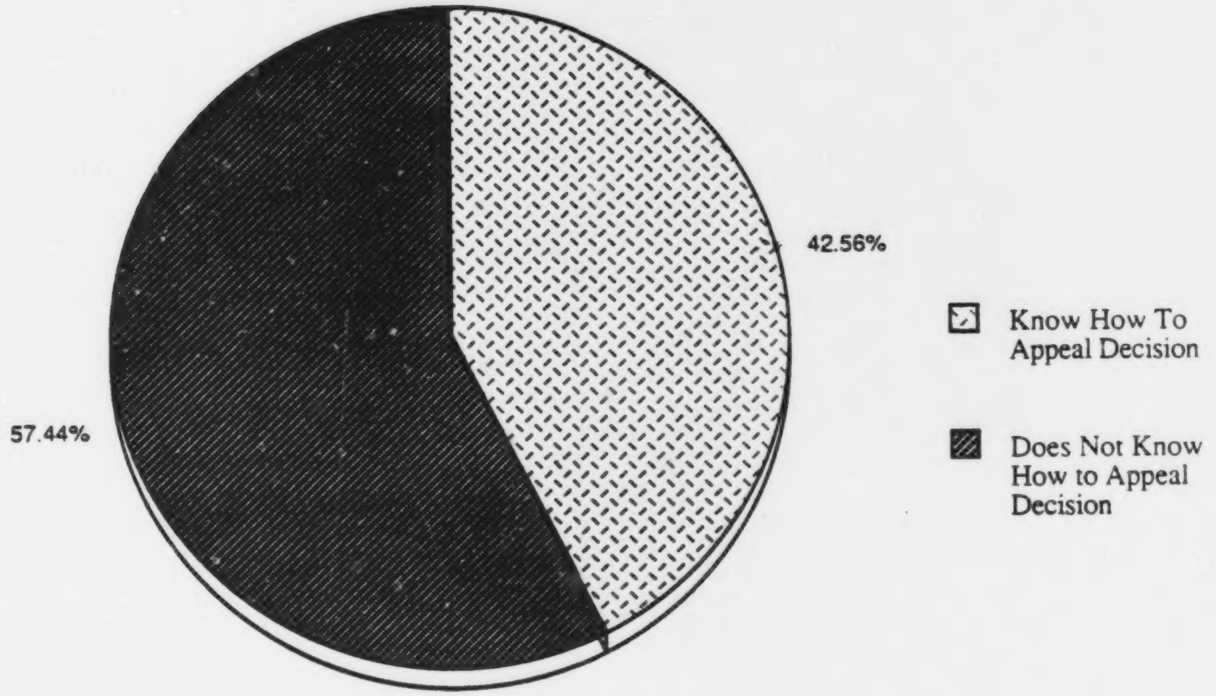
In General, How Would You Rate your Experience in Initially Obtaining Services from the Home Care/Continuing Care Program?

(n = 1001)

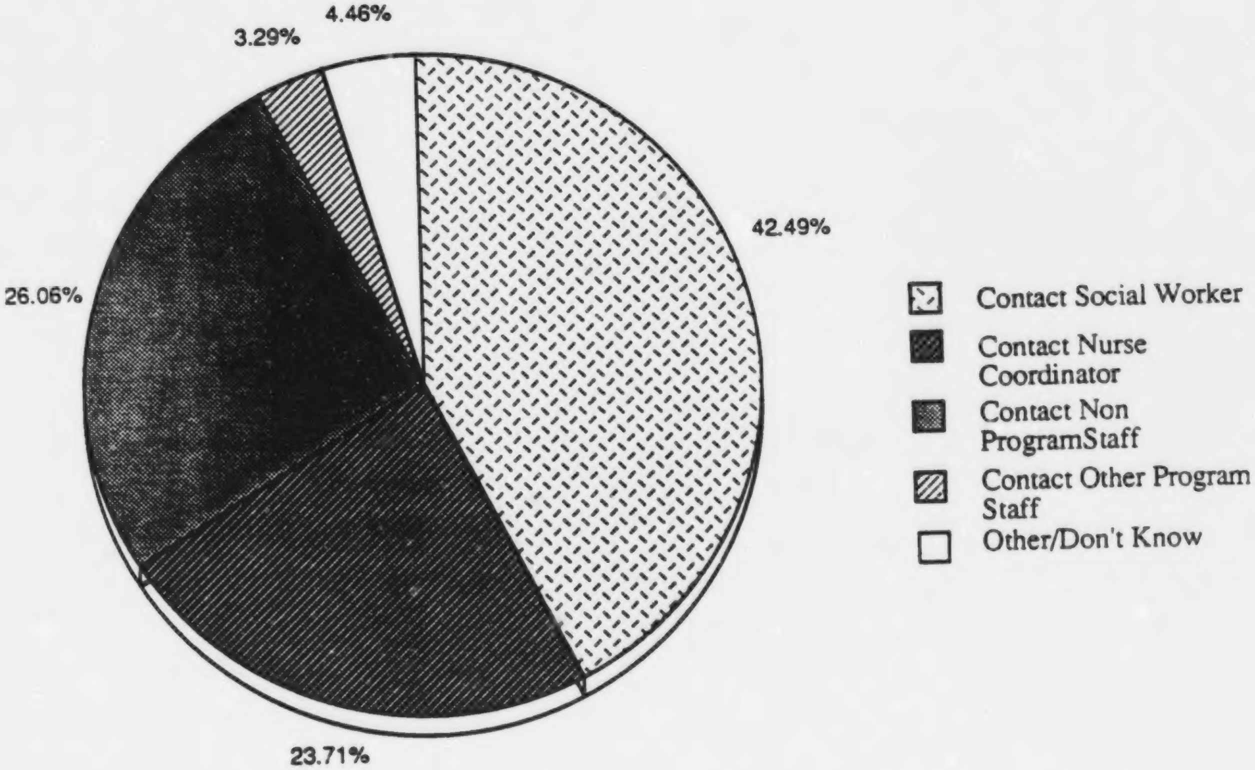


Do You Know How to Register a Complaint or How to Appeal the Service Decision of the Program Staff?

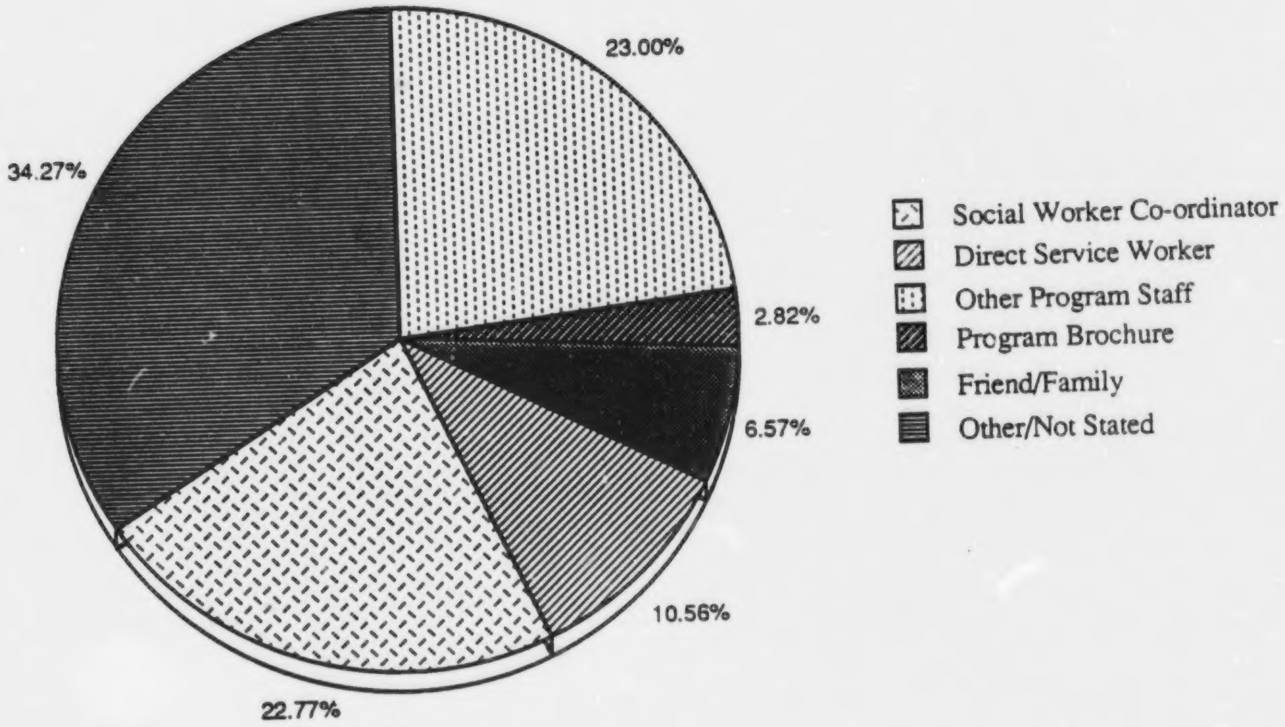
(n = 1001)



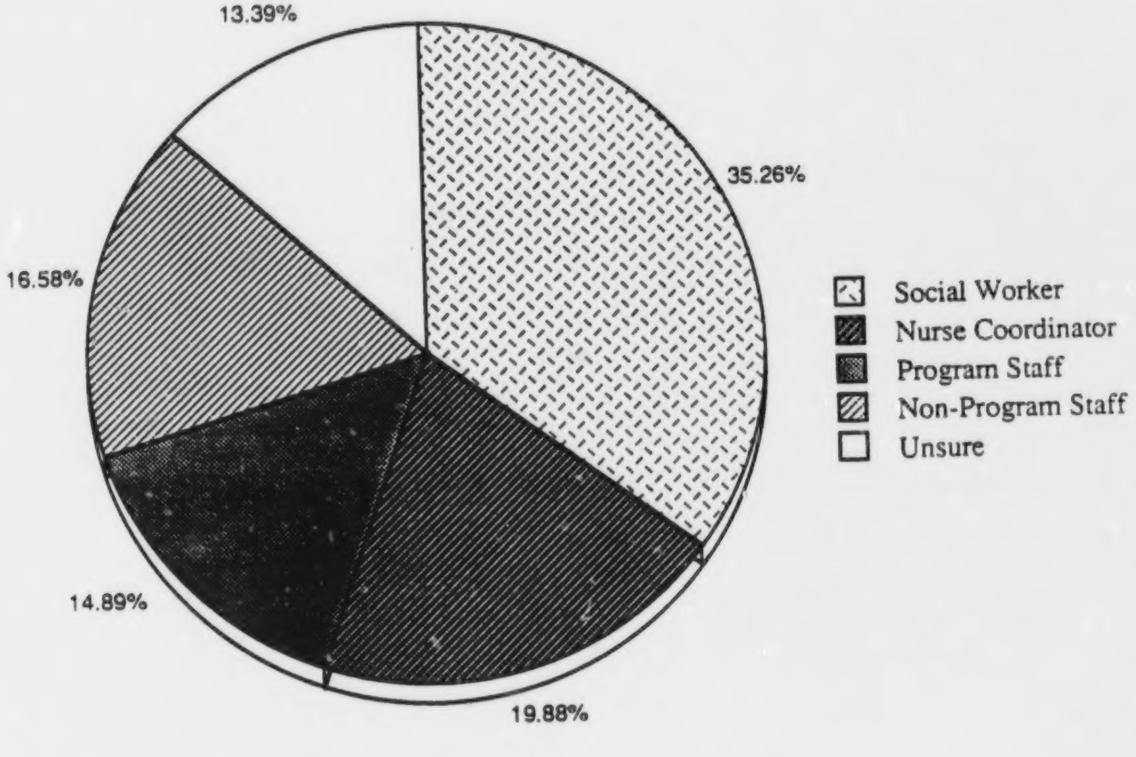
How Do You Register a Complaint?
(n = 426)



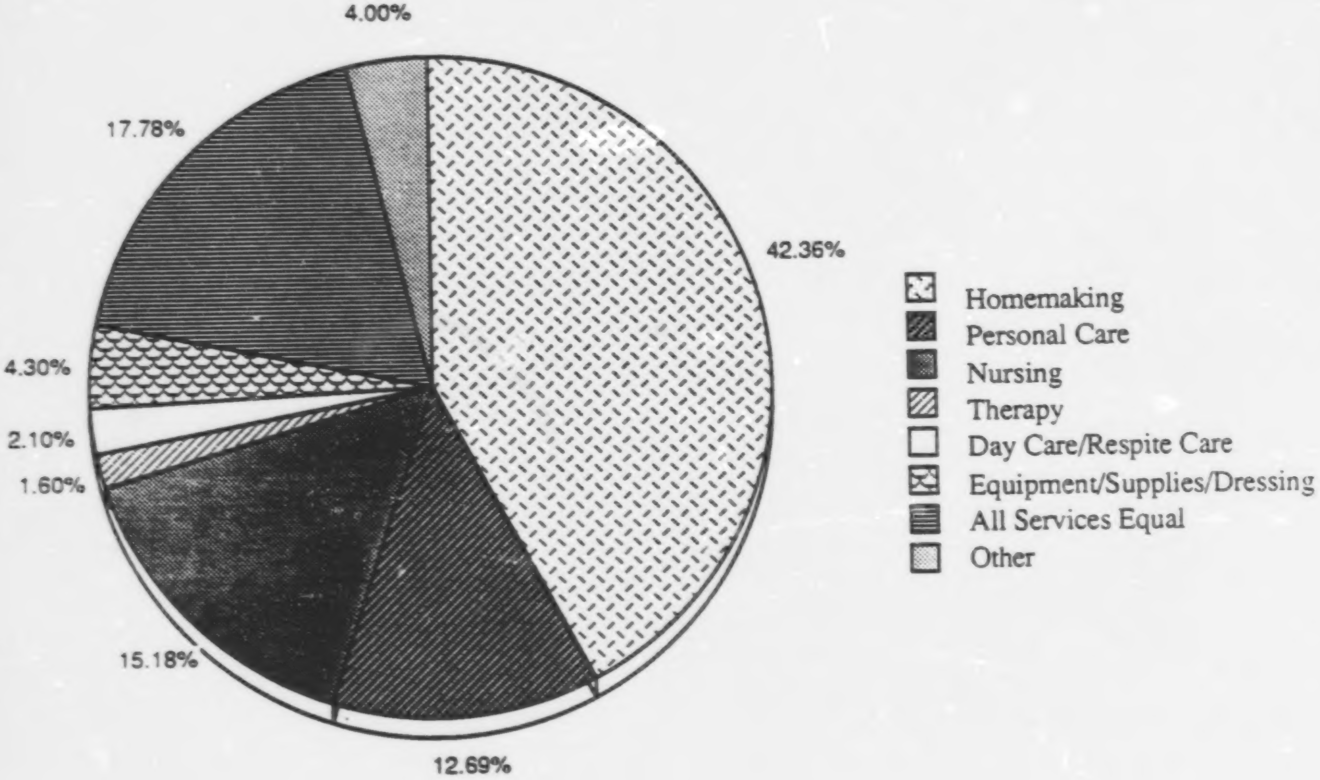
How Were You Informed About the Appeal Process?
(n = 426)



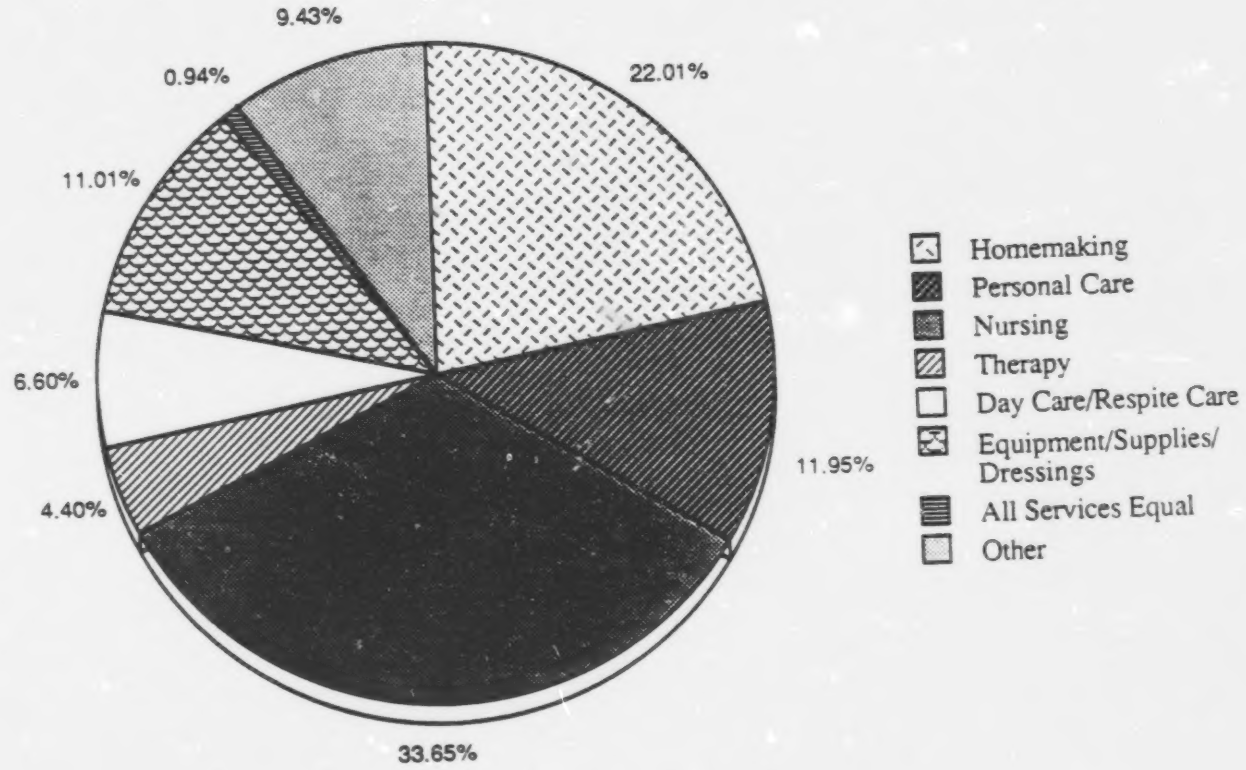
Who Would You Call if You Had a Problem with Your Services? (n = 1001)



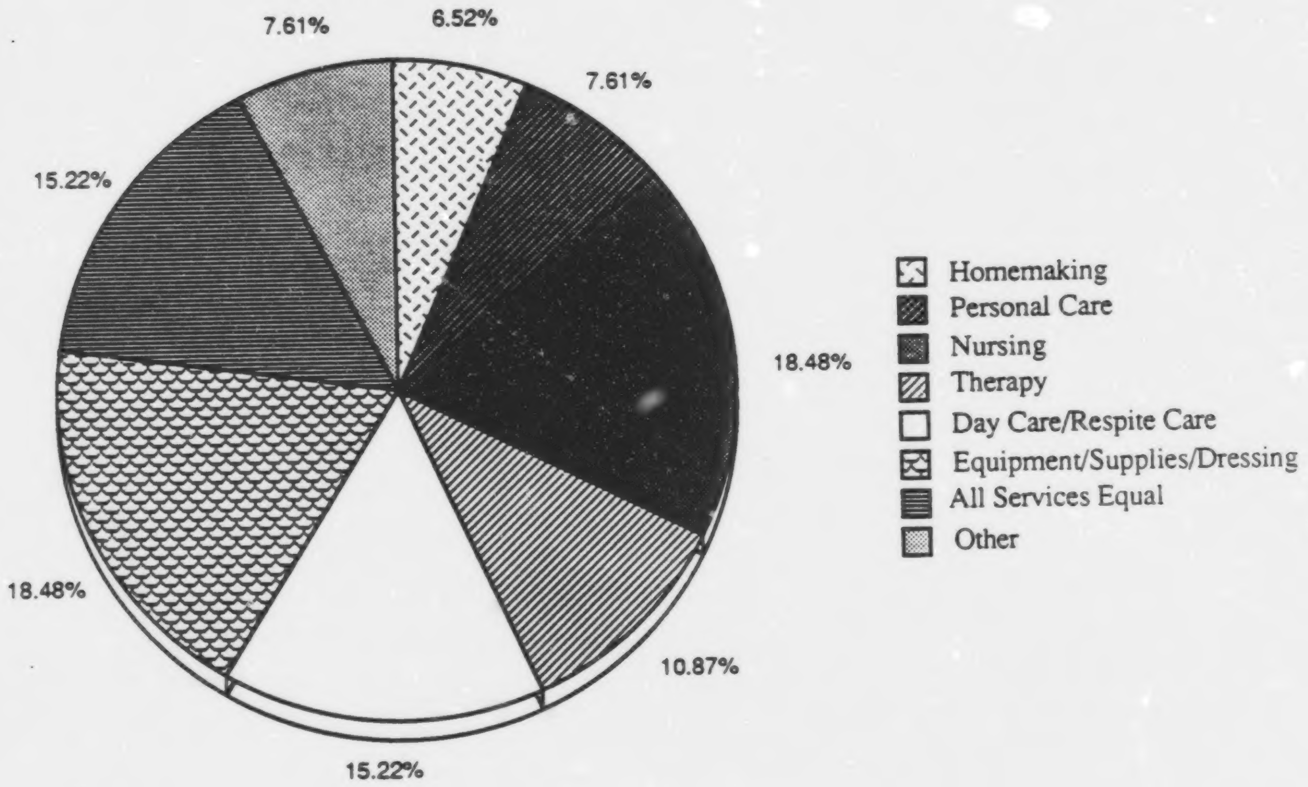
Which Service Do You Value the Most?
(n = 1001)



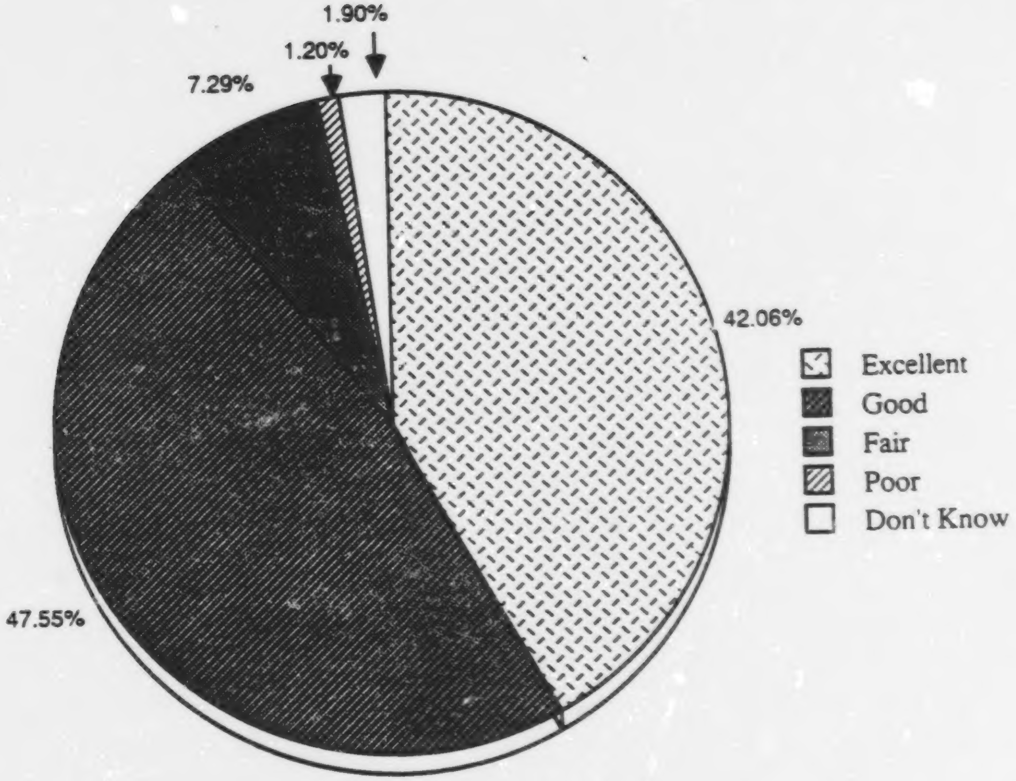
Which Services Do You Value the Second Most? (n = 318)



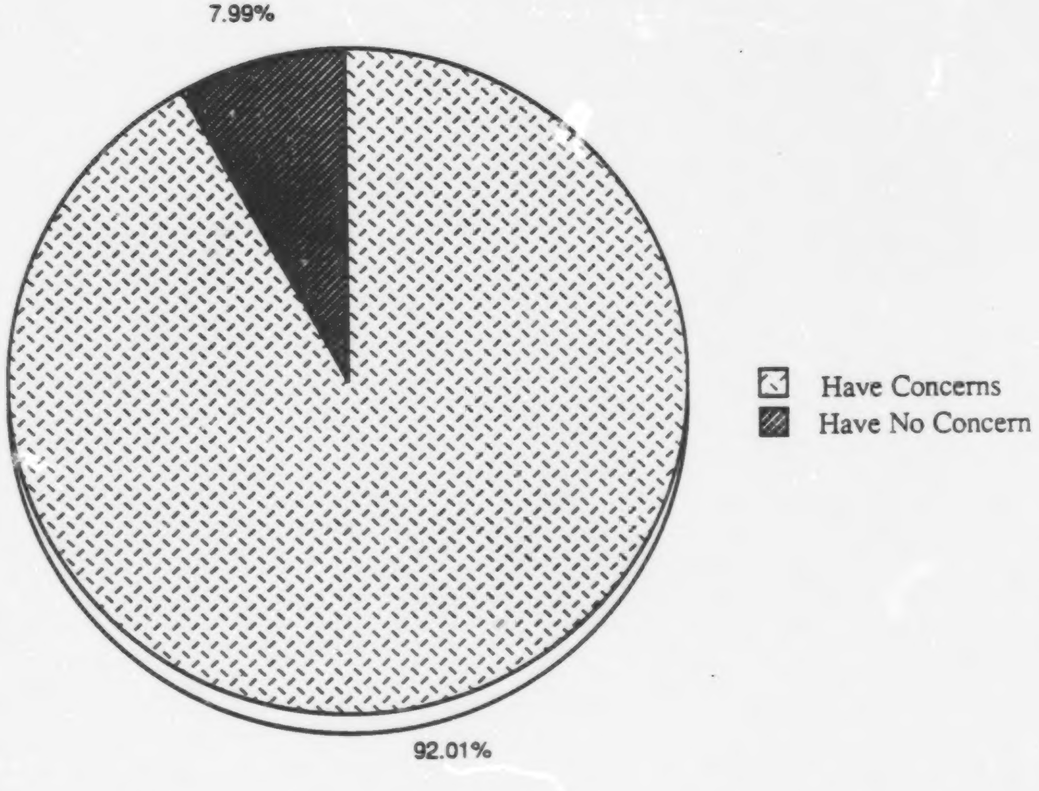
Which Service Do You Value the Third Most?
(n = 85)



Generally, How Would You Rate the Services You Are Receiving?
(n = 1001)

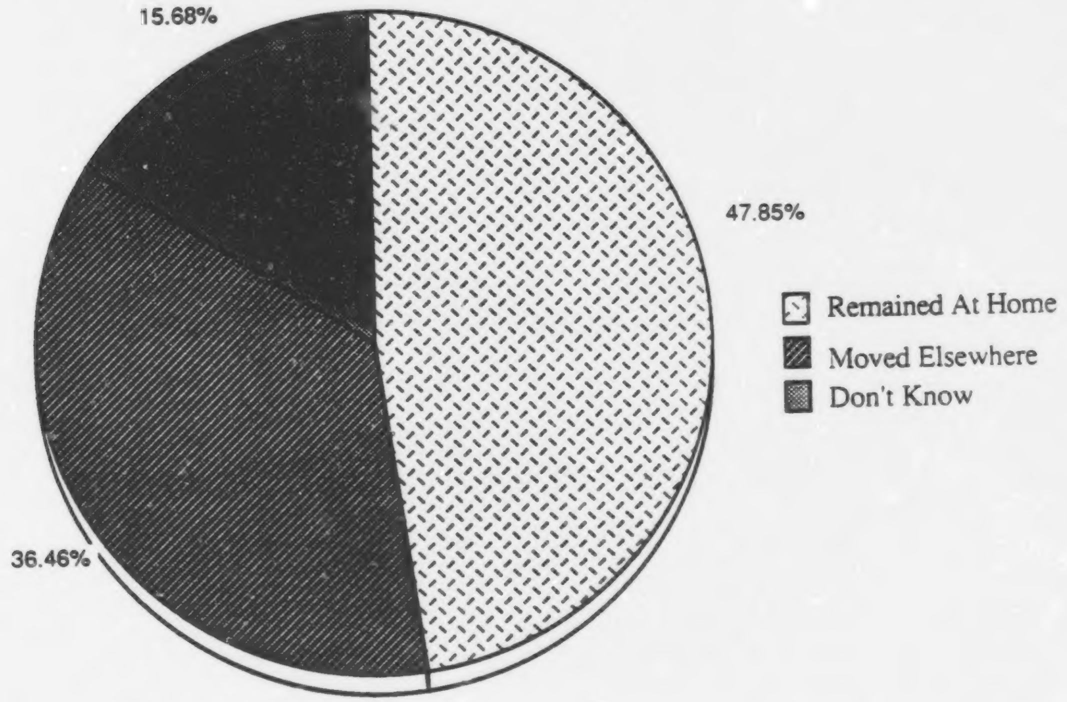


Do You Have Concerns Regarding the Home Care Services You Received?
(n = 1001)

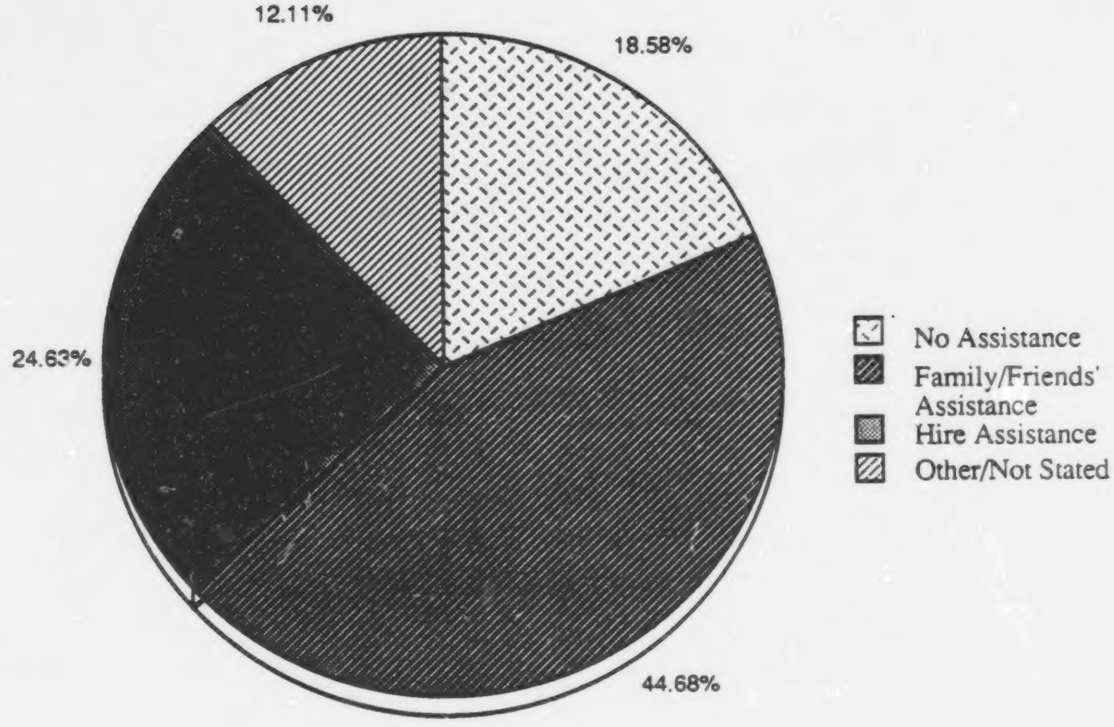


Think Back to the Time When You First Contacted the Program. What Would You Have Done if the Program Was Not Available?

(n = 1001)

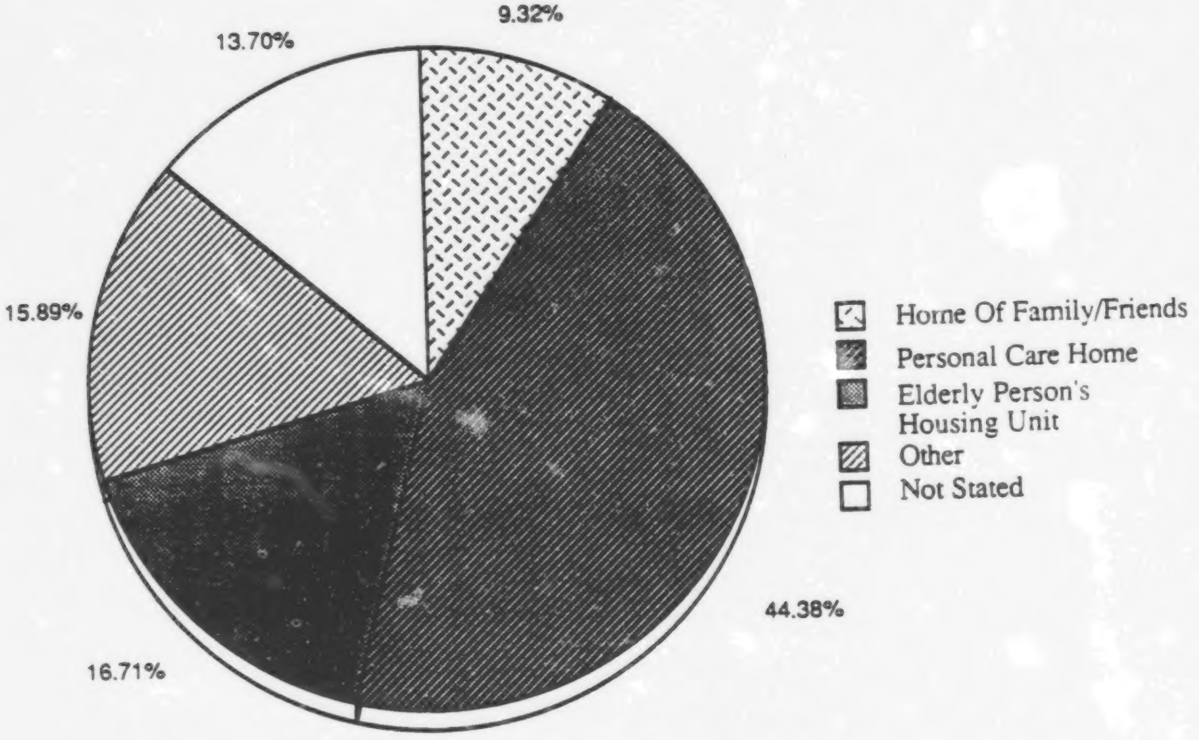


If You Remained at Home and Home Care Had Not Provided Services, Which of the Following Types of Help Would You Have Used?
(n = 1001)

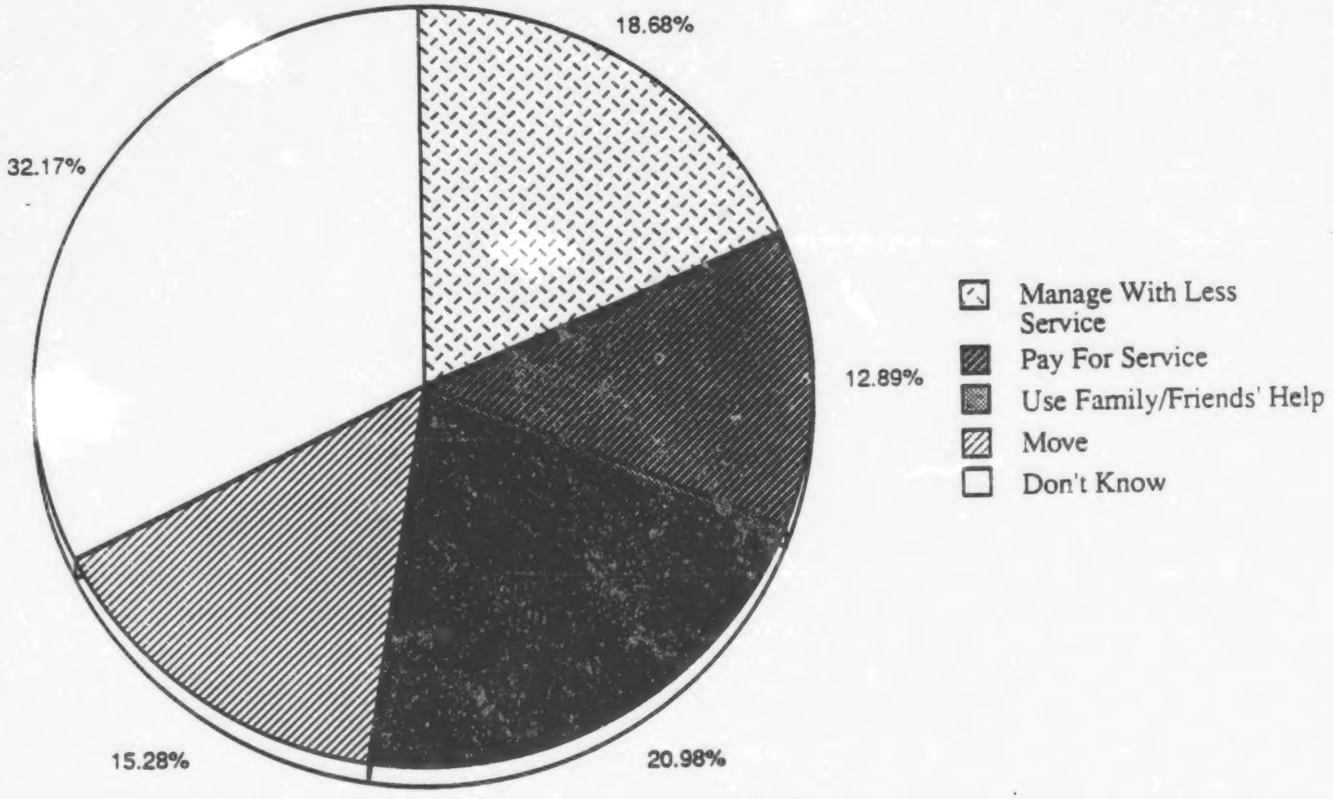


You Stated that You Would Have Moved if Home Care was not Available When You First Contacted the Program. Where Would You Have Moved?

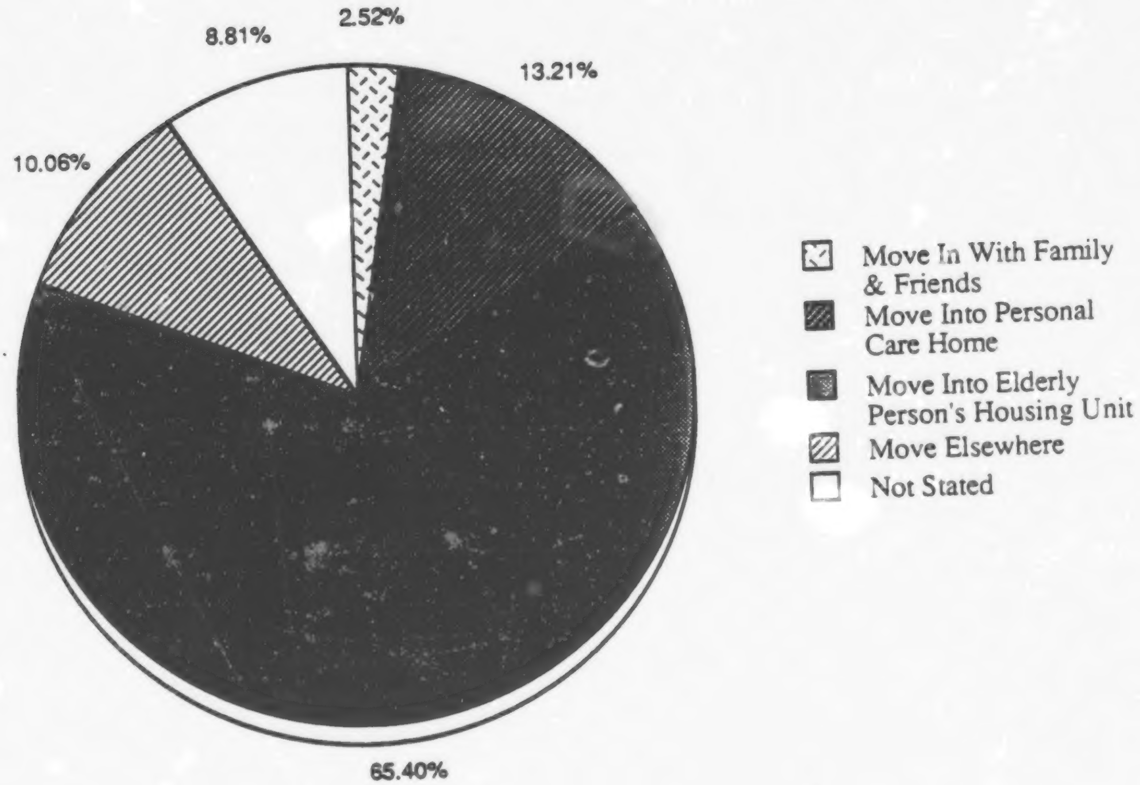
(n = 365)



Today, What Would You Do if Service Limits were Established for Home Care/Continuing Care? (n = 1001)



You Stated That You Would Move if Service Limits were Established for the Program. Where Would You Move? (n = 159)



CLIENT SATISFACTION WITH FREQUENCY OF HOME CARE SERVICES

HOME CARE SERVICE PROVIDED	SATISFIED WITH FREQUENCY	NOT SATISFIED WITH FREQUENCY	NOT STATED	TOTAL	N
Homemaking	82%	16%	2%	100%	645
Personal Care					
(Attendant)	82%	10%	8%	100%	175
(Orderly)	84%	13%	3%	100%	67
Nursing Care					
RN (VON)	89%	4%	7%	100%	338
(LPN)	92%	6%	2%	100%	87
Physiotherapy	65%	13%	22%	100%	23
Occupational Therapy	67%	19%	14%	100%	21
Adult Day Care	72%	13%	15%	100%	54
Respite Care	83%	3%	13%	99%	30
Equipment	92%	1%	7%	100%	124
Supplies/Dressings	81%	11%	8%	100%	63
Meals on Wheels	92%	8%	--	100%	38
Community Therapists	50%	13%	38%	101%	16
Other	76%	9%	15%	100%	34

CLIENT SATISFACTION WITH FREQUENCY OF HOMEMAKING SERVICES

(N-645)

Homemaking	Region/Agency			
	Rural	Winnipeg	Short-term (VON)	All Regions
satisfied with frequency	86%	79%	87%	82%
not satisfied with frequency	12%	19%	11%	16%
not stated	2%	2%	2%	2%
Total % *	100%	100%	100%	100%

* These percentages may differ from actual percentages due to rounding error.

CLIENT SATISFACTION WITH FREQUENCY OF HOMEMAKING SERVICES (by age)

(N=645)

Homemaking	Age Groups				
	0-18	19-64	65-84	85+	All Ages
satisfied with frequency	100%	76%	82%	85%	82%
not satisfied with frequency	----	21%	16%	14%	16%
not stated	----	3%	2%	1%	2%
Total % *	100%	100%	100%	100%	100%

* These percentages may differ from actual percentages due to rounding error

CLIENT SATISFACTION WITH FREQUENCY OF COMMUNITY THERAPY* SERVICES
(N=60)

Community Therapy	Region/Agency			
	Rural	Winnipeg	Short-term (VON)	All Regions
satisfied with frequency	74%	54%	54%	62%
not satisfied with frequency	17%	8%	23%	15%
not stated	9%	38%	23%	23%
Total % **	100%	100%	100%	100%

* Community Therapy includes physiotherapy and occupational therapy

** These percentages may differ from actual percentages due to rounding errors

CLIENT SATISFACTION WITH FREQUENCY OF COMMUNITY THERAPY* (by age)

(N=60)

Community Therapy	Age Groups				
	0-18	19-64	65-84	85+	All Ages
satisfied with frequency	86%	82%	49%	71%	62%
not satisfied with frequency	14%	9%	14%	29%	15%
not stated	0%	9%	37%	0%	23%
Total % **	100%	100%	100%	100%	100%

* Community Therapy includes physiotherapy and occupational therapy

** These percentages may differ from actual percentages due to rounding error

CLIENT ASSESSMENT OF NEED FOR HOME CARE SERVICES RECEIVED

HOME CARE SERVICE PROVIDED	SERVICE NEEDED	SERVICE NOT NEEDED	NOT STATED	TOTAL	N
Homemaking	93%	7%	1%	101%	645
Personal Care					
(Attendant)	86%	12%	2%	100%	175
(Orderly)	91%	9%	1%	99%	67
Nursing Care,					
RN (VON)	63%	33%	4%	100%	338
(LPN)	91%	7%	2%	100%	87
Physiotherapy	39%	44%	17%	100%	23
Occupational Therapy	52%	33%	14%	99%	21
Adult Day Care	82%	7%	11%	100%	54
Respite Care	80%	20%	---	100%	30
Equipment	79%	19%	2%	100%	124
Supplies/Dressings	65%	29%	6%	100%	63
Meals on Wheels	97%	3%	---	100%	38
Community Therapists	50%	19%	31%	100%	16
Other	79%	9%	12%	100%	34

CLIENT ASSESSMENT OF THE NEED FOR RN NURSING SERVICES

(N=338)

RN Nursing Service	Region/Agency			
	Rural	Winnipeg	Short-term (VON)	All Regions
nursing service needed	77%	83%	34%	63%
nursing service not needed	23%	13%	61%	33%
not stated	---	4%	5%	4%
Total % *	100%	100%	100%	100%

* These percentages may differ from actual percentages due to rounding error

CLIENT ASSESSMENT OF THE NEED FOR SUPPLIES/DRESSINGS

(N=63)

Supplies/ Dressings	Region/Agency			
	Rural	Winnipeg	Short-term (VON)	All Regions
service needed	80%	100%	42%	65%
service not needed	15%	----	48%	29%
not stated	5%	----	10%	6%
Total %	100%	100%	100%	100%

CLIENT ASSESSMENT OF THE NEED FOR ADDITIONAL HOME CARE SERVICES

HOME CARE SERVICE NOT CURRENTLY PROVIDED	ADDITIONAL SERVICE NEEDED	ADDITIONAL SERVICE NOT NEEDED	NOT STATED	TOTAL %	N
Homemaking	12%	84%	4%	100%	356
Personal Care					
(Attendant)	3%	93%	4%	100%	826
(Orderly)	2%	94%	5%	101%	934
Nursing Care					
RN (VON)	3%	92%	5%	100%	663
(LPN)	1%	94%	5%	100%	914
Physiotherapy	6%	89%	5%	100%	978
Occupational Therapy	3%	92%	5%	100%	980
Adult Day Care	3%	93%	4%	100%	947
Respite Care	2%	93%	4%	99%	91
Equipment	4%	92%	4%	100%	877
Supplies/Dressings	2%	94%	4%	100%	938
Meals on Wheels	4%	93%	3%	100%	963
Community Therapists	2%	93%	5%	101%	985
Other	4%	5%	91%	100%	967

CLIENT ASSESSMENT OF THE NEED TO IMPROVE HOME CARE SERVICES RECEIVED

HOME CARE SERVICE PROVIDED	NEEDS IMPROVEMENT	DOES NOT NEED IMPROVEMENT	NOT STATED	TOTAL	N
Homemaking	21%	75%	4%	100%	645
Personal Care					
(Attendant)	13%	79%	9%	101%	175
(Orderly)	16%	76%	8%	100%	67
Nursing Care					
RN (VON)	6%	87%	7%	100%	338
(LPN)	13%	82%	6%	101%	87
Physiotherapy	4%	65%	30%	99%	23
Occupational Therapy	14%	67%	19%	100%	21
Adult Day Care	9%	76%	15%	100%	54
Respite Care	7%	80%	13%	100%	30
Equipment	4%	91%	5%	100%	124
Supplies/Dressings	8%	87%	5%	100%	63
Meals on Wheels	24%	74%	3%	101%	38
Community Therapists	6%	44%	50%	100%	16
Other	3%	77%	21%	101%	34

CLIENT ASSESSMENT OF THE NEED TO IMPROVE HOMEMAKING SERVICES

(N=645)

Homemaking	Region/Agency			
	Rural	Winnipeg	Short-term (VON)	All Regions
needs improvement	15%	25%	21%	21%
does not need improvement	82%	71%	73%	75%
not stated	3%	4%	6%	4%
Total % *	100%	100%	100%	100%

* These percentages may differ from actual percentages due to rounding error

CLIENT ASSESSMENT OF THE NEED TO IMPROVE HOMEMAKING SERVICES (by age)

(N=645)

Homemaking	Age Groups				
	0-18	19-64	65-84	85+	All Ages
needs improvement	---	28%	21%	16%	21%
does not need improvement	100%	67%	76%	76%	75%
not stated	---	5%	3%	8%	4%
Total % *	100%	100%	100%	100%	100%

* These percentages may differ from actual percentages due to rounding error

CLIENT ASSESSMENT OF THE NEED FOR COMMUNITY THERAPY* SERVICES

(N=60)

Community Therapy	Region/Agency			
	Rural	Winnipeg	Short-term (VON)	All Regions
service needed	61%	33%	46%	47%
service not needed	26%	42%	31%	33%
not stated	13%	25%	23%	20%
Total % **	100%	100%	100%	100%

* Community Therapy includes physiotherapy and occupational therapy

** These percentages may differ from actual percentages due to rounding error

TABLE

Reasons Why Clients Did not Participate in Initial Home Care Service Decisions

Reason	Percentage	N
Doctors Advice	56%	143
No choice/just told what we could get	11%	27
Social Worker suggested	3%	8
I never thought about it	1%	2
Ordered while ill	3%	7
Arranged through the hospital	8%	21
They offered a particular program and we said "yes"	2%	4
Health nurse set it up	7%	19
Home Care made the decision	1%	3
Lutheran Home took care of it	0.3%	1
Other	0.3%	1
Not Stated	7%	19
Total	100%	255

TABLE

Client Reasons Why Initial Services Offered Did Not Adequately Meet Client Care Needs

Reason	Percentage	N
Need more hours of help	24%	27
Requires more services	54%	61
Problems with worker (not qualified not doing work properly)	11%	13
Never met our needs and have been cut substantially	1%	1
Care proposed but never received	4%	5
A different nurse (orderly) each time - prefer to have same one	1%	1
Needs to be placed in a personal care home	1%	1
Language barrier-needs someone to speak French	1%	1
Certain suppliers were not available to them	1%	1
Other	3%	3
Total	101%	114

APPENDIX P

FUTURE CLIENT PROFILE
AGE AND CASELOAD PROJECTION DATA

Appendix P

CASELOAD BY AGE GROUP AND PERCENTAGE OF MANITOBA POPULATION

June 1986*

Age Group	Caseload	% Pop'n *
0 - 18	289	.10%
19 - 64	2,901	.46%
65 +	11,462	8.46%

PROJECTED CONTINUING CARE CASELOAD BY AGE GROUP

June 1996*

Age Group	Maximum Month Caseload June 1996	% Change 1986
0 - 18	272	- 6%
19 - 64	3,331	15%
65 +	13,677	19%

PROJECTED CONTINUING CARE CASELOAD BY AGE GROUP

June 2006*

Age Group	Maximum Month Caseload June 2006	% Change 1986	% Change 1996
0 - 18	225	-22%	-17%
19 - 64	3,475	20%	4%
65 +	14,561	27%	7%

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* using population projection series (2) Statistics Canada (1985)

POPULATION PROJECTIONS FOR MANITOBA *

JUNE 1, 1986, 1996 AND 2006, BY AGE GROUP AND SEX
(in thousands)

Age Group	1986			1996			2006		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
0 - 18	154.9	147.0	301.9	139.6	132.2	271.8	115.8	109.4	225.2
19 - 64	315.3	319.5	634.8	332.0	334.2	666.2	347.0	348.7	695.7
65 - 84	54.4	68.9	123.3	63.2	80.2	143.4	65.8	81.8	147.6
85+	3.7	8.5	12.2	5.1	12.4	17.5	6.9	16.8	23.7
TOTALS	528.3	543.9	1,072.2	539.9	559.0	1,098.9	535.5	556.7	1,092.2

Using population projection series (2) Statistics Canada (1985)

APPENDIX Q

"HOMEMAKING ONLY" CLIENTS

APPENDIX Q

"HOMEMAKING ONLY" CLIENTS

Description

Statistics cited below may be found in the tables which follow the text of this appendix.

Twenty-eight percent of th[illegible]lients surveyed received only homemaking services. Of these two hundred and seventy-eight clients, 58% were from the Winnipeg regions, 41% were from the rural regions and 1% were V.O.N. clients.

When they first contacted the Program for services, fifty-four percent of the "homemaking only" clients would have remained at home if home care services were not available. For regions appreciably above average in this respect, the figure was:

- 76% for Westman clients;
- 65% for Winnipeg West Central clients;
- 59% for Winnipeg South;
- 58% for Parklands clients; and,
- 57% for Interlake clients.

For regions appreciably below average, the figure was:

- 44% for Winnipeg North clients;
- 29% for Eastman clients; and,
- 17% for Central clients.

Thirty-one percent of the "homemaking only" clients would have moved if home care services had not been available when they first contacted the Program. In the regions most severely affected, the figure was:

- 62% for Eastman clients;
- 50% for Central clients; and,
- 37% for Winnipeg North clients.

In the regions least affected, the figure was:

- 25% for Parklands clients;
- 23% for Winnipeg West Central clients;
- 19% for Interlake clients; and,
- 17% for Westman clients.

Finally, fifteen percent of the "homemaking only" clients did not know what they would have done if home care was not available when they first contacted the Program. For regions most affected by this uncertainty, the figure was:

- 33% for Central clients;
- 24% for Interlake clients;
- 19% for Winnipeg North clients; and,
- 17% for Parklands clients.

Discussion

On the one hand, the data above suggest that the provision of homemaking services prevented 31% of the clients currently using only homemaking services from moving out of their homes. Furthermore, since 38% of the clients who would have been forced to move stated that they would have moved into a Personal Care Home, the provision of "homemaking only" services probably contributed to the prevention of premature institutionalization.

On the other hand, 54% of the 278 clients receiving only homemaking services claimed that they would not have moved if the services were not available. In fact, of the clients who would have remained at home:

- 22% would not have replaced the service;
- 32% would have had family or friends help them with the service; and,
- 33% would have hired help.

These data suggest that over half of the clients receiving "homemaking only" services were capable of meeting these needs through their own resources without apparent financial burden.

As a result, Westman, Winnipeg South and West Central, Parklands and Interlake "homemaking only" clients were likely over serviced given their response to the survey questionnaire. This conclusion assumes, however, that clients are capable of accurately predicting their response if home care services were not available. Moreover, it assumes that clients have family/friends willing to assist with homemaking needs or can access homemaking services outside of home care.

The pattern of response to service limits continued when "homemaking only" clients were asked their reaction to the posited establishment of service limits today. The majority of clients reported an ability to manage their homemaking care needs using their own resources. There were, however, some regions that were more capable of managing than others. As well, some regions were more willing to pay for these services than other regions.

Although it is not possible from the survey data to separate homemaking services into housecleaning and meal preparation tasks, it is possible to generalize findings regarding homemaking services in total. Westman, Central and Norman regions could reduce services if non-profit agencies were available in the local communities; the clients were quite willing to pay for these services. Further, at least 25% of the Winnipeg South and West Central clients seem capable of managing with less homemaking services. In Winnipeg West Central, 42% of clients stated that they could either manage with less homemaking services or ask family and friends to help with homemaking needs. Given that, in general, a large percentage of Winnipeg clients have family living close by, service reductions should be well tolerated in Winnipeg West Central and at least bearable in the Winnipeg South region.

The Program staff are to be commended for their recognition of and action to reduce potential over servicing to "homemaking only" clients. In 1987, Caseload review across the Province focused on clients receiving only homemaking services. In one such caseload review (attended by our consultants) 10% of clients experienced a reduction in services and further service reduction of 34% of clients could be realized if a non-profit cleaning and laundry service was available locally.

Currently, through the Services to Support Seniors Program, there is money available to communities wishing to develop not-for-profit community services. It is suggested that the client survey data supports the movement towards the development of local not-for-profit homemaking agencies. Through the development of local agencies, service reduction of program clients would be realized with a subsequent reduction in Home Care costs across the Province.

FROM THE SAMPLE OF CLIENTS WHO RECEIVE ONLY HOMEMAKING SERVICES: REGIONAL DISTRIBUTION OF CLIENT RESPONSE, AFTER FIRST CONTACT WITH C.C.P., ON WHAT THEY WOULD DO IN THE ABSENCE OF THE PROGRAM

n = 278

REGION

Client Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Manage With Less Service	21%	14%	9%	14%	12%	-	50%	16%	25%	26%	-
Pay to Have Someone Deliver The Service	41%	10%	33%	19%	21%	40%	-	11%	14%	21%	-
Ask Family/ Friends to Help	21%	38%	25%	24%	8%	20%	50%	17%	14%	16%	100%
Move	7%	19%	-	10%	17%	-	-	16%	20%	7%	-
Don't Know	10%	19%	33%	33%	42%	40%	-	40%	27%	3%-	
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	29	21	12	21	24	5	2	63	56	43	2

* These figures may differ from actual figures due to rounding errors.

FROM THE SAMPLE OF CLIENTS WHO RECEIVE ONLY HOMEMAKING SERVICES: REGIONAL DISTRIBUTION OF CLIENT RESPONSE, AFTER FIRST CONTACT WITH THE C.C.P., ON WHAT THEY WOULD DO IN THE ABSENCE OF THE PROGRAM - AMONG CLIENTS WHO WOULD HAVE REMAINED AT HOME *

n = 151

REGION

Client Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Would Not Have Used Help	18%	17%	-	8%	29%	-	100%	21%	15%	39%	-
Would Have Used Help From Family/ Rel.	32%	33%	50%	33%	29%	34%	-	32%	33%	29%	100%
Would Have Hired Help	50%	50%	-	33%	35%	-	-	29%	40%	21%	-
Other	-	-	-	-	-	33%	-	-	-	-	-
Not Stated	-	-	50%	25%	7%	33%	-	18%	12%	11%	-
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	22	6	2	12	14	3	1	28	33	28	2

* These figures may differ from actual figures due to rounding errors.

FROM THE SAMPLE OF CLIENTS WHO RECEIVE ONLY HOMEMAKING SERVICES: REGIONAL DISTRIBUTION OF CLIENT RESPONSE, AFTER FIRST CONTACT WITH THE C.C.P., ON WHAT THEY WOULD DO IN THE ABSENCE OF THE PROGRAM - AMONG CLIENTS WHO WOULD HAVE MOVED

n = 86

REGION

	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Would Move:											
In with Family/ Friends	20%	31%	-	-	-	-	100%	4%	-	-	-
Into A Personal Care Home	20%	31%	33%	-	50%	-	-	48%	35%	60%	-
Into an Elderly Person's Housing Unit	40%	38%	50%	25%	-	-	-	26%	24%	20%	-
Other	-	-	-	25%	33%	100%	-	18%	6%	-	-
Not Stated	20%	-	17%	50%	17%	-	-	4%	35%	20%	-
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-
TOTAL N	5	13	6	4	6	1	1	23	17	10	-

* These figures may differ from actual figures due to rounding errors.

FROM THE SAMPLE OF CLIENTS WHO RECEIVE ONLY HOMEMAKING SERVICES: REGIONAL DISTRIBUTION OF CLIENT RESPONSE, TODAY, TO POSITED INTRODUCTION OF SERVICE LIMITS FOR HOME CARE/CONTINUING CARE *

n = 278

REGION

Client Response	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Manage With Less Service	21%	14%	9%	14%	12%	-	50%	16%	25%	26%	-
Pay to Have Someone Deliver The Service	41%	10%	33%	19%	21%	40%	-	11%	14%	21%	-
Ask Family/ Friends to Help	21%	38%	25%	24%	8%	20%	50%	17%	14%	16%	100%
Move	7%	19%	-	10%	17%	-	-	16%	20%	7%	-
Don't Know	10%	19%	33%	33%	42%	40%	-	40%	27%	3%-	
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TOTAL N	29	21	12	21	24	5	2	63	56	43	2

* These figures may differ from actual figures due to rounding errors.

FROM THE SAMPLE OF CLIENTS WHO RECEIVE ONLY HOMEMAKING SERVICES: REGIONAL DISTRIBUTION OF RESPONSE, TODAY, TO THE POSITED INTRODUCTION OF SERVICE LIMITS - AMONG CLIENTS WHO WOULD HAVE MOVED

n = 37

REGION

	Westman	Eastman	Central	Interlake	Parklands	Norman	Thompson	Wpg North	Wpg South	Wpg W. Ctrl	V.O.N./ Hosp.
Would Move:											
In with Family/ Friends	-	-	-	-	25%	-	-	-	-	-	-
Into an Elderly Person's Housing Unit	-	25%	-	50%	-	-	-	40%	27%	25%	-
Into a Personal Care Home	100%	75%	-	-	50%	-	-	50%	46%	25%	-
Other	-	-	-	-	25%	-	-	-	-	25%	-
Don't Know	-	-	-	50%	-	-	-	10%	27%	25%	-
TOTAL	100%	100%	-	100%	100%	-	-	100%	100%	100%	-
TOTAL N	2	4	-	2	4	-	-	10	11	4	-

* These figures may differ from actual figures due to rounding errors.

APPENDIX B

MANITOBA HOME CARE PROGRAM
CARE ASSESSMENT FORM

Appendix R

Manitoba
Health

Manitoba Home Care Program

Care Assessment Form

Applicant's Name	Phone No.	Date
Address	Postal Code	Home Care No.
TYPE OF ASSESSMENT ☐ Admission ☐ Reassessment		Co-ordinator
Location where assessment completed (own house, hospital, etc.)		Agency

FAMILY INFORMATION/FUNCTIONAL ASSESSMENT

1 Who lives in same household with applicant? (If none, write "none" in space.)

Name	Age	Relationship	REMARKS: (Indicate if supportive of applicant and how.)

2 List relevant family members. (If none, write "none" in space.)
Please check (✓) next of Kin or local person responsible.

Please check (✓)	REMARKS: (Indicate distance, frequency of contact, supportiveness of applicant and how.)
Name	
Address	
Name	
Address	
Name	
Address	
Name	
Address	

3 Any additional information/assessment re family functioning pertinent to assessment for/delivery of home care:

MG-8513

HOUSEHOLD INFORMATION/FUNCTIONAL ASSESSMENT

R-2

4 APPLICANT LIVES IN ☐ House ☐ Rooms ☐ Apartment ☐ Senior Citizen Housing ☐ Family Care/Foster Home

☐ Other (specify) ____________________ REMARKS: ____________________

5 INDICATE FACILITIES AVAILABLE AND ADEQUACY

	Available (type)	Adequacy (yes, no, if no explain)
HEATING		
COOKING		
REFRIGERATION		
LAUNDRY		
DRYING		
WATER		
TOILET		
BATHING		
STAIRS		
TELEPHONE		

6 Indicate if any of above facilities (including their location) affect the ability of the applicant to function in home or to get outside:

7 Indicate if any of above facilities (including their location) will affect the need for and delivery of services in the home:

8 HOUSEHOLD TASKS/MANAGEMENT	Formerly Done By Applicant Yes/No	Still Done Yes/No	REMARKS: Where still done indicate any limitations, also where not done but if formerly done indicate why not done and specify who (if anyone) now does it.
LIGHT CLEANING			
HEAVY CLEANING			
PERSONAL LAUNDRY			
HOUSEHOLD LAUNDRY			
SHOPPING			
FULL MEAL PREPARATION			
LIGHT MEAL PREPARATION			
USE PHONE			
MANAGEMENT OF OWN AFFAIRS			

9 Any additional information/assessment re household functioning pertinent to the assessment for/delivery of home care:

HEALTH INFORMATION/HEALTH FUNCTIONAL ASSESSMENT

R-3

10 **MAJOR CLINICAL FINDINGS:** (Do not repeat if on basic information sheet.)
Diagnosis/Extent of Disability:

Diagnosis Known:
To Family ☐ Yes ☐ No
To Applicant ☐ Yes ☐ No

11 **CLINICAL HISTORY:**

12 **ALLERGIES:** if any, describe

13 Medication	Dosage	Frequency	Route	Prescribed By	Date

Ability to Administer: Independent ☐ Requires Assistance ☐ Specify

Compliance:

14 Current prescribed treatments, if any: Indicate applicant's ability to manage own treatment.
Independent ☐ Requires Assistance ☐ Specify

15 Have clinical findings/treatment been confirmed with attending physician? ☐ Yes ☐ No
If Yes, how. If No, what is the plan for confirmation?

16 **NUTRITION:** Is applicant eating adequately: ☐ Yes ☐ No Is applicant on special diet? ☐ Yes ☐ No
COMMENTS:

17 Any additional information/assessment re physical health functioning pertinent to the assessment for/delivery of home care:

PERSONAL CARE INFORMATION/FUNCTIONAL ASSESSMENT

REMARKS: Should reveal any patterns/inconsistencies;
Should include any current or planned treatment/intervention;
Should cover implications for self care, for socialization.

18 SIGHT: **REMARKS:**

Wears glasses ☐ Yes ☐ No

____ Adequate for all activities

____ Inadequate for some activities (specify)

____ Inadequate for personal safety (specify)

19 HEARING:

Wears hearing aid ☐ Yes ☐ No

____ Adequate for all activities

____ Inadequate for some activities (specify)

____ Inadequate for personal safety (specify)

20 COMMUNICATION:

____ Gestures only ____ Written only

____ Adequate for all activities

____ Inadequate for some activities (specify)

____ Unable to communicate

21 AMBULATION:

____ Independent with or without mech. aid

____ Outdoors with assistance

____ Indoors amb. with assistance

____ Stairs with assistance

____ Stairs independent

____ Cannot manage stairs

____ Wheelchair independent

____ Wheelchair with assistance

22 TOILETING

CONTINENCE	MANAGEMENT
____ Completely continent	____ Independent
____ Incontinent urine, occasionally	____ Dependent (elaborate)
____ Incontinent urine, night only	☐ Catheter
____ Incontinent urine, always	☐ Ostomy
____ Incontinent feces, occasionally	☐ Condom Drainage
____ Incontinent feces, always	☐ Bathroom Routine
	☐ Other Aids

23 TRANSFERRING:

REMARKS:

____ Independent

____ Bed to chair with assistance

____ Bedfast, can turn self in bed

____ Bedfast, must be turned in bed

24 EATING:

Dentures: ☐ Upper ☐ Lower

____ Independent

____ Requires assistance or encouragement

____ Has to be fed

25 DRESSING:

____ Independent

____ Requires assistance or encouragement

____ Has to be dressed/undressed

26 BATHING:

____ Independent

____ Can sponge bath self

____ Can bath only with assistance or encouragement

____ Has to be bathed

27 CARE OF HAIR:

____ Independent

____ Requires assistance or encouragement

____ Cannot care for own hair

28 FOOT CARE

____ Independent ____ Cannot care for own feet

____ Requires Assistance

29 CARE FOR PROTHESIS:

Where applicable, indicate type of prothesis and ability of applicant to care for such.

Any additional information/assessment re personal care functioning pertinent to the assessment for/delivery of home care:

PSYCHO/SOCIAL INFORMATION/FUNCTIONAL ASSESSMENT

30 Has applicant's living pattern/role in family or household altered in past year? Describe showing whether there has been change or loss and indicate whether (how) applicant is coping. Look for indicators of loneliness, bereavement or loss of status.

31 Describe how applicant spends his/her time in a typical day at home and indicate if applicant describes his/her activities as being meaningful to others, to self or simply as a means of passing time.

32 Are there any activities which the applicant formerly was engaged in at home which he/she now misses? Why? Could the applicant be involved again in the same or similar activity with assistance/intervention? What?

33 Neighbours, friends in contact with applicant:		REMARKS: (Indicate frequency of contact and supportiveness to applicant and in what way.)
Name	Phone #	
Address		
Name	Phone #	
Address		
Name	Phone #	
Address		
Name	Phone #	
Address		

34 Describe applicant's involvement in community (include church, legion, fraternal, etc.)

35 Are there any community activities in which the applicant formerly was involved which he/she now misses? Could the applicant be involved again with assistance/intervention? What?

36 **Does travel outside the home affect applicant's ability to participate in activities, to receive medical care, to manage the household, etc.? If so, describe why, how and intervention indicated.**

37 **Specify cultural/religious preferences of applicant relevant to delivery of home care services (language, special food, etc.)**

REMARKS: **Should reveal any patterns/inconsistencies;**
Should include any current or planned treatment/intervention;
Should cover implications for self care, for socialization.

38 **MENTAL STATUS:** ____ **Completely oriented** ____ **Forgetful/confused occ.** ____ **Disoriented**	**REMARKS:**
39 **MOOD:** ____ **Seems content** ____ **Seems concerned about specific problem** ____ **Seems somewhat tense and anxious** ____ **Seems depressed** ____ **Unusual, unpredictable behavior (specify)** ____ **Not motivated for some activities (specify)**	
40 **MOTIVATION:** ____ **Motivated for all activities** ____ **Not motivated for some activities (specify)** ____ **Not motivated for most activities**	
41 **JUDGEMENT IN PRESENT SITUATION:** ____ **Realistic** ____ **Adequate for personal safety** ____ **Limited ability to make judgements** ____ **Unrealistic**	

42 **Any additional information/assessment re psycho/social functioning pertinent to assessment for/delivery of home care:**

SUMMARY ASSESSMENT

Under the following headings indicate the area(s) (if any) where the applicant cannot meet need through self-functioning or through the services of available family or others, and which, if the need is not met, places the applicant at risk of not being able to remain in the community-or-places the applicant at risk of deterioration which could directly contribute toward inability to remain in the community.

Where the applicant's ability to remain in the community is dependent upon the service of others in the household or in the community, show where the relief of such providers is realistically indicated for continued living in the community.

HOUSEHOLD MAINTENANCE NEEDS

HEALTH NEEDS

PERSONAL CARE NEEDS

PSYCHO/SOCIAL NEEDS

SUPPLIES/EQUIPMENT NEEDS

APPENDIX S

WORKLOAD MEASUREMENT TOOL

WINNIPEG SOUTH

Appendix S

	PHYSICAL CARE			HEALTH CARE								SOCIAL SUPPORT								
CLIENT'S NAME	Resource Co-ordin.	Orderly	Family-Ext. Fam. Friends	V.O.N.	Supplies	Community Therapy Services	L.P.N.	R. N.	Day Hospital	Physician Care 1 x|mo. or more	Family Ext. Fam. Friends	Youville-Sr. Clermont Health Plan	Community Agencies	N.H.P.	Respite	Day Care	Volunteers	Family Ext. Fam. Friends	Client Supports	High Risk Medium Risk Low Risk

Definitions:

Low (blue) - 1-2 categories and 1-3 services

Medium (green) - 2 or more categories and 4-5 services

High (red) - 2 or more categories with 6 or more services

Family|Ext. Family|Friends

1. Physical Care
    - household maintenance
    - hygiene
    - dressing
    - feeding|meal prep.
2. Health Care
    - medications - assisting with set-up or ensuring they take meds.
    - dressings
3. Social Support
    - like replacing a volunteer
    - taking to appts.
    - grocery shopping
    - providing social interaction on a regular basis

APPENDIX T

DIRECT SERVICE WORKER SURVEY DATA

APPENDIX T

DIRECT SERVICE WORKER SURVEY

CONTENTS

EXHIBIT

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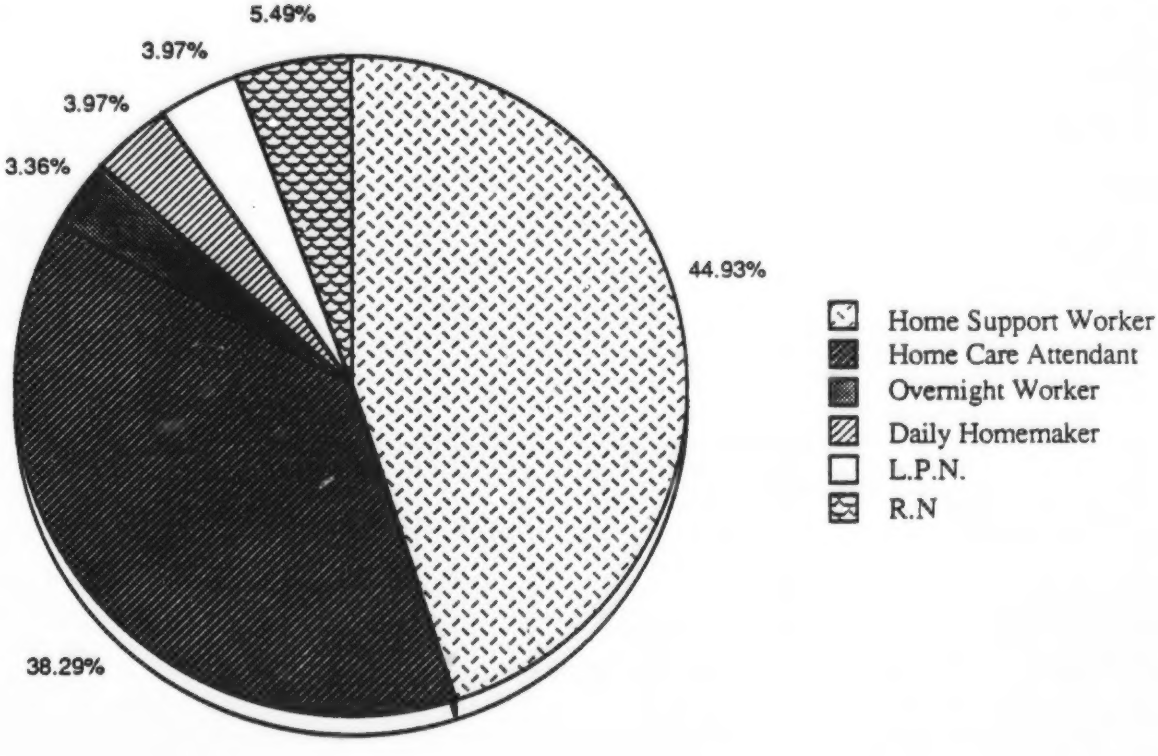
T-15 AREAS FOR WORK IMPROVEMENT
T-16 OTHER COMMENTS

What Type of Work Are You Employed to Do by the Continuing Care Program? (n = 1311)



Home Care Direct Service Worker Employment Location

Direct Service Worker	City %	Town %	Area %	Total %	N
Home Support	45%	41%	14%	100%	589
Home Care Attendent (orderly)	35%	42%	23%	100%	502
Overnight Worker	48%	34%	18%	100%	44
Daily Homemaker (24 Hours)	56%	29%	15%	100%	52
Licensed Practical Nurse	44%	48%	8%	100%	52
Registered Nurse	12%	53%	35%	100%	72

Direct Service Worker Response to the Need for Specialized Training

Direct Service Worker	Specialized Training		Total %	N
	Yes	No		
Home Support	22%	78%	100%	589
Home Care Attendant (orderly)	68%	32%	100%	502
Overnight Worker	32%	68%	100%	44
Daily Homemaker (24 hours)	15%	85%	100%	52
Licensed Pratical Nurse	100%	-	100%	52
Registered Nurse	100%	-	100%	72

Specialized Training Received by Home Care Direct Service Workers

Direct Service Workers	Through C.C.P.		Before Employment with C.C.P.					
	HCA course	HSW course	HCA course	HSW course	Other	Nursing course	Total %	N
Home Support	22%	62%	4%	2%	10%	-	100%	128
Home Care Attendent (orderly)	73%	2%	6%	-	19%	-	100%	341
Overnight Worker	50%	7%	29%	-	14%	-	100%	14
Daily Homemaker (24 hours)	50%	-	-	-	50%	-	100%	8
Licensed practical Nurse	-	-	-	-	-	100%	100%	52
Registered Nurse	-	-	-	-	-	100%	100%	72

Direct Service Worker Response to the Adequacy of Training to Perform Home Care Services

Direct Service Workers	Adequate Training		Total %	N
	Yes	No		
Home Support	89%	11%	100%	589
Home Care Attendant (orderly)	87%	13%	100%	502
Overnight Worker	89%	11%	100%	44
Daily Homemaker (24 hours)	90%	10%	100%	52
Licensed Practical Nurse	96%	4%	100%	52
Registered Nurse	99%	1%	100%	72

Area of Additional Training Required for Individuals Who Feel Their Training is Inadequate

Direct Service Workers	Little Training	Emergency Training	General Training	Specific Diseases (Alzheimer)	Dealing with clients	HSW/HCA	Other	Total %	N
Home Support	10%	27%	8%	18%	14%	13%	10%	100%	62
Home Care Attendant (orderly)	42%	11%	12%	12%	8%	3%	12%	100%	65
Overnight Worker	-	50%	25%	-	-	25%	-	100%	4
Daily Homemaker (24 hours)	-	-	50%	-	25%	-	25%	100%	4
Licensed Practical Nurse	-	-	100%	-	-	-	-	100%	2
Registered Nurse	-	-	100%	-	-	-	-	100%	1

Direct Service Worker Response to the Ability to Maintain Current Skills

Direct Service Workers	Maintaining Skills		Total %	N
	Yes	No		
Home Support	97%	3%	100%	589
Home Care Attendant (orderly)	93%	7%	100%	502
Overnight Worker	100%	-	100%	44
Daily Homemaker (24 Hours)	100%	-	100%	52
Licensed practical Nurse	81%	19%	100%	52
Registered Nurse	81%	19%	100%	72

Direct Service Worker Identification of Skill Maintenance Concerns

Direct Service Workers	Skill Under Utilized	More Continuing Education Needed	Other	Total %	N
Home Support	71%	7%	22%	100%	14
Home Care Attendant (orderly)	58%	24%	18%	100%	33
Overnight Worker	-	-	-	-	-
Daily homemaker (24 hours)	-	-	-	-	-
Licensed Practical Nurse	82%	9%	9%	100%	11
Registered Nurse	53%	33%	14%	100%	15

Work Instructions *

Direct Service Worker	Phone/from Coordinator	Resource Coordinator /from Coordinator	Written /Task Sheets	From Case Coordinator	From Schedule Clerk	Office	Doctor /Nurse	Client /Family	Dispatcher	Other	Total %	N
Home Support	35%	17%	20%	9%	10%	4%	2%	2%	-	1%	100%	743
Home Care Attendant (orderly)	35%	29%	8%	15%	6%	2%	2%	1%	2%	-	100%	492
Overnight Worker	37%	16%	23%	11%	2%	2%	-	7%	-	3%	100%	62
Daily Homemaker (24 hours)	52%	14%	17%	7%	3%	5%	-	-	-	2%	100%	58
Licensed practical Nurse	28%	3%	24%	30%	1%	4%	10%	-	-	-	100%	76
Registered Nurse	32%	4%	25%	18%	-	3%	16%	2%	-	-	100%	102

* Some respondents checked more than one contact person.

Direct Service Worker Response to Clarity of Work Instructions

Direct Service Workers	Clear Instructions		Total %	N
	Yes	No		
Home Support	93%	7%	100%	589
Home Care Attendant (orderly)	88%	12%	100%	502
Overnight Worker	96%	4%	100%	44
Daily Homemaker (24 hours)	92%	8%	100%	52
Licensed Practical Nurse	87%	13%	100%	52
Registered Nurse	97%	3%	100%	72

CCP staff member identified by Direct Service Worker as contact for work instruction clarification *

Direct Service Worker	Schedule Clerk	Resource Co-ordinator	Case Co-ordinator	Other	Total %	N
Home Support	22%	31%	43%	4%	100%	615
Home Care Attendant (orderly)	11%	33%	51%	6%	101%	527
Overnight Worker	11%	38%	49%	2%	100%	45
Daily Homemaker (24 hours)	7%	41%	45%	7%	100%	54
Licensed Practical Nurse	2%	83%	11%	4%	100%	54
Registered Nurse	3%	78%	12%	7%	100%	74

* Some respondents checked more than one contact person

Suggested Improvements to Clarify Instructions as submitted by Direct Service Workers who Felt Work Instructions were not Clear

Direct Service Workers	More Client personal/ medical information	Instructions should be written	Better Client Assessments	Improved Coordinator Unfamiliar with tasks	Reduce Coordinator workload	Better Client task Education	Other	Total %	N
Home Support	26%	8%	13%	8%	11%	8%	26%	100%	38
Home Care Attendant (orderly)	31%	22%	21%	5%	-	-	21%	100%	58
Overnight Worker	-	50%	50%	-	-	-	-	100%	2
Daily Homemaker (24 hours)	-	50%	25%	-	-	-	25%	100%	4
Licensed practical Nurse	29%	43%	-	-	-	-	28%	100%	4
Registered Nurse	50%	-	-	-	-	-	50%	100%	2

Direct Service Worker Procedure When Client's Condition/Needs Change

Direct Service Workers	Contact Resource Coordinator	Contact Case Coordinator	Contact Dr./Nurse Ambulance	Contact Schedule Clerk	Contact Family	Contact Office	Contact Social worker	Other	Total %	N
Home Support	30%	45%	6%	8%	6%	3%	1%	1%	100%	707
Home Care Attendant (orderly)	39%	46%	3%	4%	3%	2%	2%	2%	100%	502
Overnight Worker	25%	52%	12%	4%	4%	2%	-	2%	100%	52
Daily Homemaker (24 hours)	11%	61%	5%	2%	11%	5%	5%	-	100%	62
Licensed Practical Nurse	10%	59%	19%	8%	1%	-	-	3%	100%	73
Registered Nurse	7%	53%	34%	-	5%	1%	-		100%	105

Direct Service Worker Reported Dissatisfactions with Continuing Care Program

Direct Service Worker	Admin[1] Dissatisfaction	Job Related[2] Dissatisfaction	Client[3] Related Dissatisfaction	Other[4] Dissatisfaction	Total %	N
Home Support	40%	19%	16%	25%	100%	477
Home Care Attendant (orderly)	62%	14%	8%	16%	100%	463
Overnight Worker	55%	21%	6%	18%	100%	33
Daily Homemaker (24 hours)	52%	13%	6%	29%	100%	31
Licensed Practiced Nurse	44%	22%	4%	30%	100%	50
Registered Nurse	50%	28%	11%	11%	100%	74

[1] Administrative Dissatisfaction Examples:
More hours, better benefits, higher wages, less split shifts

[2] Job Related Dissatisfaction Examples:
More continuing education, less task restrictions, proper supervision, fewer mundane tasks, written instructions

[3] Client Related Dissatisfaction Examples:
More personal/medical information, improved client task education, more family involvement

[4] Other Dissatisfaction Examples:
Public education, career path, ombudsman

Direct Service Worker Response to Areas for Work Improvement

	IMPROVEMENTS					
Direct Service Workers	Administrative	Job Related	Client Related	Other	Total %	N
Home Support	55%	21%	11%	13%	100%	523
Home Care Attendant (orderly)	54%	25%	9%	12%	100%	464
Overnight Worker	37%	37%	17%	9%	100%	30
Daily Homemaker (24 hours)	49%	20%	9%	22%	100%	35
Licensed Practical Nurse	31%	42%	2%	25%	100%	48
Registered Nurse	26%	42%	14%	18%	100%	57

Direct Service Worker Response to 'General Comments Question' regarding Home Care Program

Direct Service Workers	Administrative Related comments	Job Related comments	Client Related comments	Other comments	Total %	N
Home Support	45%	9%	7%	39%	100%	522
Home Care Attendant (orderly)	47%	11%	6%	36%	100%	478
Overnight Worker	23%	10%	7%	60%	100%	30
Daily Homemaker (24 hours)	15%	28%	3%	54%	100%	39
Licensed Practical Nurse	19%	21%	4%	55%	99%	47
Registered Nurse	17%	20%	13%	50%	100%	64

APPENDIX U

DIRECT SERVICE WORKER FOCUS GROUP SUMMARY POINTS

Appendix U

Direct Service Worker Focus Group
Summary Findings

	Region A	Region B	Region C	Region D
Orientation and Training:				
inadequate work orientation	X	X	X	
inadequate continuing education	X	X	X	X
Work Assignments:				
generally fair	X	X	X	X
inadequate communication	X	X	X	
inadequate supervision	X	X		X
inadequate client information	X	X	X	
inadequate scheduling:				
excessive travel	X	X		
inadequate travel allowance	X	X	X	X
insufficient hours and split shifts	X	X	X	X
Client Assessments:				
generally appropriate		X	X	X
Improvements to Program:				
more client social time	X	X		X
more time to complete tasks	X			
improved client task education	X	X		
improved public awareness			X	
an ombudsman	X	X		
more client family support	X	X	X	X
better LPN utilization	X	X		
improved office support after hours	X	X	X	X
easier access to HCA/HSW courses		X		
less workers per client		X		
formalized policies and procedures	X	X		
a worker career path			X	
means testing				X
less unsafe working conditions		X		X
Job Satisfaction:				
high, as gratifying to help others	X	X	X	X
high, as flexible hours		X		X
coordinators are very helpful			X	X
Improvements to Job Satisfaction:				
more hours	X	X	X	X
better wages	X	X	X	X
benefits	X	X	X	X
recognition	X	X	X	X

X = identified by direct service workers as existing in the Region

APPENDIX V

RESPITE AND ADULT DAY CARE PROGRAM
DESCRIPTION AND STATISTICS

The Adult Day Care Program, founded in 1979, is funded by the Manitoba Health Services Commission although clients pay $3.50/day for each day that they attend the Program. In accomplishing its mandate of supporting independent living, the Adult Day Care Program provides an opportunity for peer socialization, recreation and group activities in a supportive environment. The program also provides a nutritious meal to clients in attendance. Participants are referred to the program by regional staff of the Continuing Care Program.

The Respite Program, founded in 1980 provides planned short term admission/re-admission to the Personal Care Home for the purpose of providing relief for the primary care giver. Referrals to the Respite Program are also through the Continuing Care Program. This program is also funded by the Manitoba Health Services Commission.

The number of individuals utilizing the services as well as the number of sponsors has increased. Both the Respite and Adult Day Care Programs have grown since their inception.

Data regarding the two programs can be found in the two tables following the text of this appendix.

ADULT DAY CARE PROGRAM * STATISTICS

1979/80 - 1987/88

	1979/80	1980/81	1981/82	1982/83	1983/84	1984/85	1985/96	1986/87	6 months 1987/88
No. Sponsors	18	22	29	30	35	45	50	52	55
No. Days of Care	1,648	8,783	15,433	20,994	26,919	30,218	36,276	44,194	24,009
No. of Individuals Served/Quarter	144	204	352	431	540	642	781	906	921

	1980/81	1981/82	1982/83	1983/84	1984/35	1985/96	1986/87
Annual Increase in Days of Care (%)	432%	78%	36%	28%	12%	20%	22%
Annual Increase in # of Individual served/Quarter (%)	42%	73%	22%	25%	19%	22%	16%

* Program began in 1979

RESPITE CARE IN PERSONAL CARE HOME PROGRAM * STATISTICS

1981/82 - 1987/88

	1981/82	1982/83	1983/84	1984/85	1985/86	1986/87	6 months 1987/88
No. Sponsors	22	27	24	23	23	27	24
No. Persons	163	241	285	330	362	421	290
No. Cases	246	390	470	525	600	657	380
No. Days	3,794	5,995	6,974	8,085	8,510	9,262	5,205

	1982/83	1983/84	1984/85	1985/86	1986/87
Annual Increase in Days of Respite Care (%)	58%	16%	16%	5%	9%
Annual Increase in Person Using Respite Care (%)	48%	18%	16%	10%	16%

* Program began in 1980

APPENDIX W

FINANCIAL POLICIES AND FINANCIAL ROLES AND RESPONSIBILITIES SECTIONS FROM THE FINANCIAL ADMINISTRATION MANUAL

Financial Administration Manual

Subject Number	6C-1.2
Subject	DEPARTMENTAL SYSTEMS INTRODUCTION POLICIES
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1. Each department shall clearly define its financial systems in terms of fundamental purpose and objectives of each system in order to facilitate effective development, implementation, control and evaluation to ensure planned accomplishments occur.

2. All components of a department's financial system shall be identified as either:

   - a financial administrative system;
   - a program related financial system;

3. All financial systems of each department shall be under the direct control of the department's executive financial officer;

4. Financial systems shall fulfill financial and accounting requirements under the Financial Administration Act and the Financial Administration Manual.

5. Each department shall establish and maintain a current properly documented inventory of all its financial systems.

6. All new systems or revisions to a department's financial system shall be developed in accordance with sound systems development methodology.

7. New or revised departmental financial systems shall be subject to security and control and shall include audit trails to protect the integrity of computerized systems.

8. Departmental financial systems shall ensure accuracy, completeness, and timeliness of relevant outputs and financial reporting.

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9. Departmental financial systems shall interface where appropriate with central financial systems including delineation of roles and responsibilities.

10. Departmental financial systems shall be periodically evaluated against original objectives in terms of meeting planned outputs. An evaluation checklist is recommended to carry out an effective assessment relative to costs and alternatives.

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DEPARTMENTAL FINANCIAL FUNCTION
ROLES AND RESPONSIBILITIES

The roles and responsibilities of senior personnel involved with the execution of the financial function within the departmental context are:

Role of the Minister - When a department is established (or continued) by an Act, and otherwise by convention, the Minister shall reside over and have charge of the Department and is responsible for the administration of Acts within the Department's jurisdiction.

Role of the Deputy Minister - Deputy Ministers are appointed by Order-in-Council as the chief administrative officers of departments working under the direction or subject to the approval of the Minister. The Deputy Minister is accountable for the Department's financial administration even though specific authority for its management may be delegated.

Role of the Executive Financial Officer - The Minister may formally delegate the authority for the Department's financial administration to an executive officer on the recommendation of the Deputy Minister. This individual who has the overall responsibility to ensure compliance with government policy on financial management and administration reports to the Deputy Minister. Specific responsibilities of the Executive Financial Officer include:

- Ensuring that the key activities of financial management are carried out effectively and in a cost-efficient manner.
- Advising the Minister and the Deputy Minister on the financial implications of decisions in both the planning and operating phases.
- Establishing and administering financial policies, systems and procedures for the Department.
- Maintaining a close working relationship with the Comptroller at central level.
- Exercising functional leadership over line managers on matters concerning financial management within the Department.
- Overseeing organizational arrangements, staffing and training matters of the financial components of the Department and ensuring a full capability to deliver support and information to central government and the Department as required.
- Ensuring a performance review of the financial officers within the Department is carried out.

Role of the Senior Financial Officer - The Executive Financial Officer is often responsible for a number of specialized functions in addition to financial management, for example, administrative support, personnel management and data processing. Therefore, it is necessary to designate an officer who will be directly responsible for the departmental financial management on a full-time basis. This financial officer is referred to as the Senior Financial Officer. The Senior Financial Officer is a functional specialist in the management of financial activities. Specific responsibilities include:

- Management of key financial activities.
- Advice to the Executive Financial Officer, Executive Committee of the Department, and the Deputy Minister on the needs of the financial management system and the financial implications of decisions in the planning and operating phases.
- Development of financial policy within the Department for approval by the Executive Financial Officer.
- Advice on the application of legislative, regulatory and other financial directives from Treasury Board, Minister of Finance and central government.
- Directing the development and operation of a communication network for the departmental system of financial management.
- Maintaining the system of financial management and ensuring that the system is compatible with the government-wide financial network.
- Overseeing organizational arrangements, staffing and training matters within financial units to ensure their capability in delivering financial services as required.
- Reviewing performance appraisals on financial officers within the Department.

Roles of the Program/Responsibility Centre Manager - The primary role of the program or responsibility centre manager is to manage the human, physical and financial resources placed at his or her disposal to ensure that the outputs and benefits contribute to the objectives of the Department in an economical, efficient and effective manner. From the perspective of the financial function, these managers have certain financial authorities and responsibilities delegated to them, as follows:

- The authority to initiate expenditures and certify satisfactory contract performance.

- The responsibility to ensure that:
  - sufficient funds are available to meet all expenditure obligations they enter into,
  - all public money due the Province has been claimed,
  - all assets (including assets in trust) are properly accounted for, protected and recorded,
  - all financial information is properly identified and reflected in the financial reports, and
  - the system of financial management operates effectively within their area of responsibility.